# Reports and Research

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August 20, 2015 Board Meeting

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  August 2015

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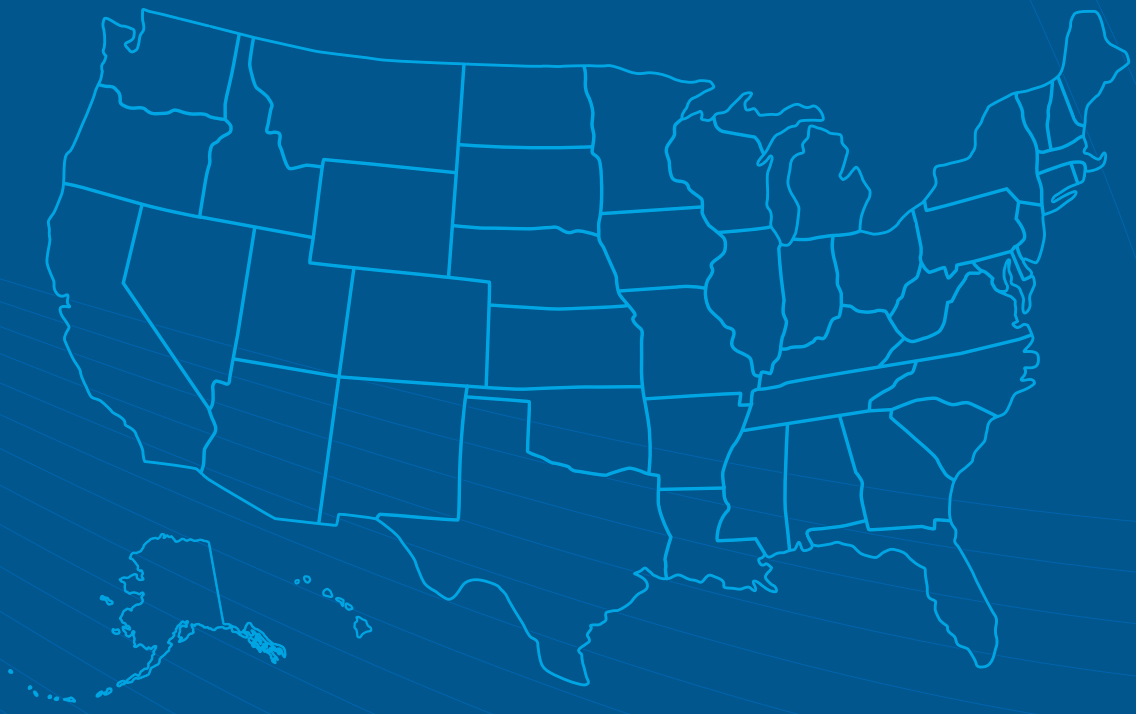
# Enhancing the Patient-Centeredness of State Health Insurance Markets

## State Progress Reports



PUTTING PATIENTS FIRST®
NATIONAL HEALTH COUNCIL

Founded in 1920, the NHC is the only organization that brings together all segments of the health community to provide a united and effective voice for the more than 133 million people living with chronic diseases and disabilities and their family caregivers. Made up of more than 100 national health-related organizations and businesses, its core membership includes the nation's leading patient advocacy organizations, which control its governance. Other members include professional and membership associations, nonprofit organizations with an interest in health, and major pharmaceutical, health insurance, medical device, and biotechnology companies.

**The National Health Council State Progress Reports are made possible with the generous support from the initiative's premier sponsor, Novartis Pharmaceuticals Corporation.**

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## A Message for Members and Partners /

The National Health Council (NHC) and its members are committed supporters of Affordable Care Act (ACA) provisions that provide the greatest benefit to people with chronic diseases and disabilities. Since the passage of the ACA, the NHC has worked to strengthen these protections so that patients can access health insurance that meets both their health and budget needs.

As members and partners of the NHC, you and your organizations can help carry this message to state policymakers and regulators. The ACA's insurance market reforms, coverage expansions, and subsidies are significant steps forward for the patient community. However, the successful implementation of these steps relies on states to continue and even expand their role as regulators of their health insurance market. State support is critical to guaranteeing the ACA's goals of high-quality and affordable health care for all.

These state Progress Reports illustrate the variability of the patient-centeredness of health insurance markets across states. Members, partners, and the NHC will use these reports to identify states where changes could improve access to coverage and care for patients. These reports also can identify leading states that set best practices for patient-friendly requirements.

Remember, the specific reforms that are appropriate to one state may not be the right fit for all states. The goal of these reports is to encourage states to implement a range of reforms in the key areas that will have the most benefit to patients—non-discrimination, transparency, oversight, uniformity, and continuity of care.

Your actions to move these policies forward can have a lasting effect on the lives of all patients.

## Background /

### Exchange Operational Models

The ACA established sweeping insurance reforms that included the introduction of health insurance exchanges, where individuals and families can shop for health insurance coverage. While each state has its own exchange, the federal government plays a role in managing exchanges in many states. In general, states followed one of three paths to establish an exchange—a state-based exchange, a state-partnership exchange in which the state and federal government share exchange responsibilities, or a federally-facilitated exchange. Each model envisions a different role for states, and, as a result, the federal government. However, the federal government sets basic operating standards for all exchanges.

<table>
<tr><th></th><th>STATE-BASED EXCHANGE</th><th>STATE PARTNERSHIP EXCHANGE</th><th>FEDERALLY-FACILITATED EXCHANGE</th></tr>
<tr><td>NUMBER OF STATES</td><td>16 + DC</td><td>6</td><td>29</td></tr>
<tr><td>Plan Management</td><td rowspan="3">State</td><td rowspan="2">State</td><td rowspan="3">Federal</td></tr>
<tr><td>Consumer Assistance</td></tr>
<tr><td>Eligibility and Enrollment</td><td rowspan="2">Federal</td></tr>
<tr><td>Financial Management</td><td></td></tr>
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### The Role of States

Each exchange model relies on states to ensure that plans comply with state insurance laws and to enforce some aspects of the ACA.[1] Therefore, every state has the opportunity to establish additional standards and requirements that ensure patients have access to coverage that meets their needs.

## Project Purpose /

These Progress Reports aim to identify the state-by-state variation in patient friendliness of insurance exchanges to:

- Promote policies that help protect patients, and
- Discourage policies that are inconsistent with patient needs.

## Methodology and Sources /

The National Health Council (NHC) works to ensure that the protections put in place by the ACA are implemented in the best interest of patients. As part of these efforts, the NHC prioritizes five key prin ciples of a truly patient-focused insurance market—non-discrimination, transparency, oversight, uniformity, and continuity-of-care.

### Non-discrimination

Confirm plan designs do not discriminate or impede access to care, including a provider network that ensures patients can access care when they need it.

### Transparency

Provide access to clear and accurate information for consumers about covered services and costs in exchange plans, including a user-friendly exchange website.

### State oversight

Ensure all exchange plans meet applicable state and federal requirements, including the state's plan management requirements and rate review.

### Uniformity

Create standards to make it easier for patients to compare exchange plans, such as a quality scorecard and standardized plan materials.

### Continuity of care

Broaden sources of coverage and protect patients transitioning between plans, including expanded Medicaid.

To understand how insurance markets perform against these priorities, the reports assess each state using a set of metrics. The metrics represent specific, measurable, and actionable goals for each state's insurance market and exchange.

States are assigned scores for each metric, based on an evaluation of the state's action or market in relation to its effect on patients:

- ● Beneficial scores are assigned to states with policies or insurance market dynamics resulting in better access or choice for patients.
- ◐ Neutral scores are assigned to states without policies that result in better access or choice for patients.
- ● Negative scores are assigned to states with policies or insurance market dynamics resulting in reduced access or choice for patients.

1 Five states (Alabama, Missouri, Oklahoma, Texas, and Wyoming) have declined to play any role in oversight or enforcement of the ACA.

Then, the Progress Reports compare performance on all metrics within each principle across states, yielding state-by-state assessments for all five principles. This step determines whether states are high-performing, average-performing, or low-performing for each principle.

High-Performing  Average-Performing  Low-Performing

The analysis is based on a proprietary database of policy developments for all 50 states and the District of Columbia, maintained by Avalere Health. Progress Reports also reference publicly available resources, cited where applicable. The score for each metric was based on states' performance as of January 1, 2015. These reports reflect policies in effect for the 2015 exchange market and do not include proposed measures or actions. Additionally, Avalere conducted a focused review of selected topics for state exchange insurance markets, though this assessment is not intended to be a comprehensive review of all legislation and regulations pertaining to states' insurance markets.

## Promising Practices across States /

While all states have taken steps to enhance the patient experience, some states have set particularly high standards for patient-centered exchange markets. In fact, the states highlighted below have implemented policies that represent models for other states considering changes to their insurance markets

### Non-discrimination

Since the launch of exchanges, there has been limited federal and state action to examine plan benefits for discrimination. Currently, most states follow guidance from the federal government to ensure that exchange plan benefits are not discriminatory. Some states have enacted measures to limit opportunities for discrimination in the exchanges and to ensure patients have adequate access to services and providers.

**Washington,** an SBE, is a leader in fighting discrimination in the exchange market, receivingbeneficial scores across each non-discrimination metric. Specifically, Washington issued regulations that limit discrimination in exchange plans by setting increased standards for coverage and grant the insurance commissioner broad authority to reject plans with discriminatory benefits. This heightened level of authority allows the state to better protect patients from discriminatory benefits before they come to the market. Additionally, the state also took action to ensure that patients have adequate access to providers, and that under certain conditions in-network costs apply to out-of-network providers. This helps to ensure that patients receive timely and affordable treatment. Further, Washington has several platinum plan choices, giving patients with significant health needs a choice of plans with additional benefits and cost-sharing protections.

Montana, an FFE, established a new requirement to ensure that benefit designs do not discriminate or impede access to care for patients. Specifically, the state requires issuers to offer at least one silver, gold, and platinum exchange plan that uses copayments (rather than coinsurance) and that does not subject any drugs to the deductible, including the specialty tier.

State efforts to prevent, identify, and mitigate potential discrimination can make a big difference for patients with chronic conditions and disabilities, who rely on the protections afforded by the ACA.

## Transparency

In states across the nation, patients have limited access to transparent, easy-to-understand, complete information about the covered services and costs of exchange plans. Most exchange websites, including HealthCare.gov, have links to plan materials, such as the formulary and provider directory. Yet, linked resources are a challenge to navigate, particularly for patients with complex conditions who need to compare the intricate details of plan coverage and costs.

In addition, some, but not all, exchanges include decision support tools, such as search tools and out-of-pocket calculators, to help patients navigate different plan choices. While most exchange websites have sort and filter functions, these features do not adequately assist patients in selecting an appropriate plan. Across the country, very few states have taken action to help increase transparency standards around covered services and costs of exchange plans. This challenges patients as they are trying to make informed plan selections.

Maryland, an SBE, is trailblazing a path for transparency standards among exchange plans. First, the state's exchange website features one decision support tool—a provider search engine – that helps patients chose a plan that includes their doctor. Additionally, the state requires plan documents to include specific information. For example, formularies must include the tier placement and cost sharing for each drug covered by the plan. Also, when issuers file their plans with the state, the documentation must include a list of medicines covered under the plan's medical benefit.

## State Oversight

State oversight of exchange plans is critical to ensuring a patient-centered market. Some states enhance the oversight of the plans offered on exchanges by negotiating with carriers regarding the number of product offerings or requiring plans to offer more than silver and gold metal level plans. Other states use the rate review process to ensure that plan premiums reflect the benefits offered and that any increase in premium from year to year is justified. In most instances, well-regulated insurance markets attract a healthy number of carriers offering exchange plans, which increases competition and choice for patients. These types of measures ensure that exchange plans meet applicable requirements and that the market is competitive, allowing patients to have more options when selecting coverage.

Massachusetts, an SBE with the distinction of offering the first health insurance exchange in the country, has long acted to ensure the state has effective oversight of exchange plans. The state is considered an active purchaser, meaning the exchange negotiates with insurers, chooses which carriers can offer exchange plans, and sets criteria for participating plans. For example, Massachusetts has twelve carriers in the exchange, and each of these carriers is required to offer plans at all four metal levels, ensuring that patients have a broad set of options from which to select a plan that best meets their needs.

Michigan, an FFE, also has taken notable steps to have adequate oversight of exchange plans. The state requires issuers to standardize offerings inside and outside of the exchange, which unifies and stabilizes both markets and ensures that patients might be equally served by plans in either market.

## Uniformity

States have acted to make it easier for patients to compare exchange plans. Some SBEs have standardized the benefit designs for plans at all metal levels—creating uniform cost-sharing structures for all benefits across all plans at each metal level. Six SBEs—California, Connecticut, Massachusetts, New York, Oregon, and Vermont—have standardized exchange plans in this way. Other states have taken less intensive approaches to improve plan comparisons, either by establishing plan quality rating systems or by standardizing plan materials to follow a particular template.

California, an SBE, has led other states in its efforts to improve the comparability of exchange plans. Key protections in the state include the standardized benefit designs across all metal levels, including the cost-sharing reduction versions of silver plans that are available to people with limited income. The state does not allow any non-standard plans in the exchange, which is unique among states with standardized plans. These requirements mean that all people enrolled in the same metal level plan in the state encounter the same cost sharing for the same benefits; in effect, it levels the playing field. California has implemented a quality rating system that assigns plans up to four stars using the results of consumer surveys. Finally, the state requires plans to update their formularies monthly and is developing a standard template required for plan formularies, beginning in 2017.

### Continuity of Care

Actions to ensure continuity-of-care between plans or types of coverage can help patients maintain access during transition period. For example, when patients enroll in a new exchange plan for the following plan year or when eligibility for Medicaid or subsidized exchange coverage shifts, patients are at risk for problems accessing care during the change in coverage. In fact, the Medicaid expansion is itself an opportunity for states to expand coverage to low-income individuals who cannot qualify for exchange subsidies. Other states offer enhanced premium subsidies beyond assistance offered from the federal government or established bridge plans to help individuals whose income is on the border between Medicaid and subsidized exchange eligibility. Bridge plans are a type of health insurance option for people whose eligibility for Medicaid and exchange coverage might shift from year to year. Some states are creating these plans as a more stable option for patients to ensure they have consistent access to coverage and care.

Delaware, an SPE, created transition periods for people whose eligibility for public programs changes, including those moving from Medicaid into exchange plans. The requirements allow people to access prescriptions for 60 days and medical treatments for 90 days to ensure patients can maintain their treatment plans while changing plans or sources of coverage.

Vermont, an SBE, funds cost-sharing reduction subsidies for a larger group of exchange enrollees than the federally funded program. The expanded population includes individuals and families with income between 250% and 300% of the federal poverty level, expanding the population of people who are eligible for this extra financial assistance in the state.

## Areas for Actions /

Following the first full year of exchanges, some states have emerged as leaders in implementing patient-centered standards and reforms. However, there is more work left to do.

Given the challenges leading up to exchange implementation and the Medicaid expansion, some states prioritized operational and technical readiness over patient-friendly tools and standards. Now that HealthCare.gov and most SBE websites are operating effectively, it is important for states to begin to turn their attention to ensuring that all people have access to coverage and care that meets their needs.

Opportunities exist for patient advocates to work with states to improve the patient-friendliness of their insurance markets in the coming years. NHC partners may consider the following three issues as they develop their advocacy plans for the 2016 and 2017 plan years.

## State and Federal Considerations /

These reports identify states creating some of the nation's most patient-friendly insurance markets as leaders that can help to pave the way for other states. At the same time, they also uncover some key areas for improvement to make the exchanges truly patient centered. Together with advocacy groups and aligned partners, states can use their performance across the metrics as starting points to begin to move exchange markets in favor of helping patients access better and more affordable care. Throughout the course of advocacy efforts, one must be mindful of the following points:

### Understand the State Audience

Advocates can leverage their insight into the state's dynamic to target the right audience with the applicable message at the appropriate time. Some of the metrics identified in these reports represent approaches to insurance markets on which both sides of the political spectrum can agree (i.e. transparency). These types of less contentious, bipartisan policies are good starting points for some states looking to secure new protections for patients. Other states with a more active legislative or regulatory history on exchanges might be good targets for more complex patient-centered measures, such as standardized benefit designs, supplemental premium subsidies, or cost-sharing caps.

### Consider the Federal Government

Members and partners also should consider the role the federal government plays to establish standards for many of these priority areas. Current federal standards are quite limited in their patient centeredness, offering significant opportunity to make adjustments that would lead to enhanced patient protections for many, or even all, states. With so many states using HealthCare.gov and following other federal standards, national requirements may offer substantial influence over markets across multiple states in the near term.

## Moving Forward /

The National Health Council is dedicated to ensuring that the ACA achieves its objectives of high quality and affordable care for all people, including those with chronic diseases and disabilities. Understanding the landscape of patient-centeredness across all states can begin conversations that lead to positive changes for patients in these markets. The NHC will continue to work with members and partners as they engage with states and the federal government to ensure the exchange markets offer the most equitable, affordable, and highest quality coverage and care possible for patients.

## Increase State Oversight and Regulation of Exchange Markets

Currently, most states rely upon limited federal guidance for the methods they should use to ensure that exchange markets are not discriminatory. Few states have taken steps to further define their plan reviews and oversight activities. Most SBEs are not actively negotiating with plans to participate in the exchange. And, though most states have an effective rate review process, additional standards in this area can further influence premium rates among exchange plans. Finally, most SBEs have not set contracting standards for participation in the exchange, such as requiring that the issuers offer plans across all metal levels. These types of oversight actions can help to ensure that patients can access appropriate and affordable choices in the exchanges.

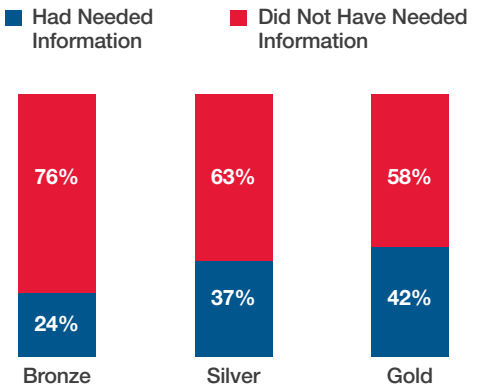
## Support Implementation of Robust Quality Rating Systems in All Exchanges

The SBEs of Connecticut, Hawaii, Idaho, Kentucky, and Vermont have not yet released information about their quality rating systems. SBEs have the option to implement their own standards by 2017 or to follow the federal approach. For FFEs, public reporting of quality ratings and enrollee satisfaction will occur for the 2017 open enrollment period. NHC partners have the opportunity to work with states and the federal government to encourage rating systems that measure the experience of patients in plans and also appropriately reward plans for focusing on patient-centered care.

## Ensure Medicaid Changes and Expansions Offer Protections Afforded under the Traditional Program

A state's approach to Medicaid expansion should ensure that patients have increased access to coverage and care, while preserving the patient protections guaranteed under the program. In 21 states, Medicaid has not been expanded to individuals and families with incomes below 138% of the federal poverty level, leaving many patients without any access to affordable health coverage. Another six states used waivers to allow the state to enroll eligible individuals and families into exchange plans rather than traditional Medicaid. Though these waivers do expand access to coverage, advocates and states should work together to ensure that Medicaid enrollees in these states have the full protections afforded under traditional Medicaid.

**Figure 1. Share of Respondents Who Reported Having "All the Information They Needed" When Choosing a Health Plan**



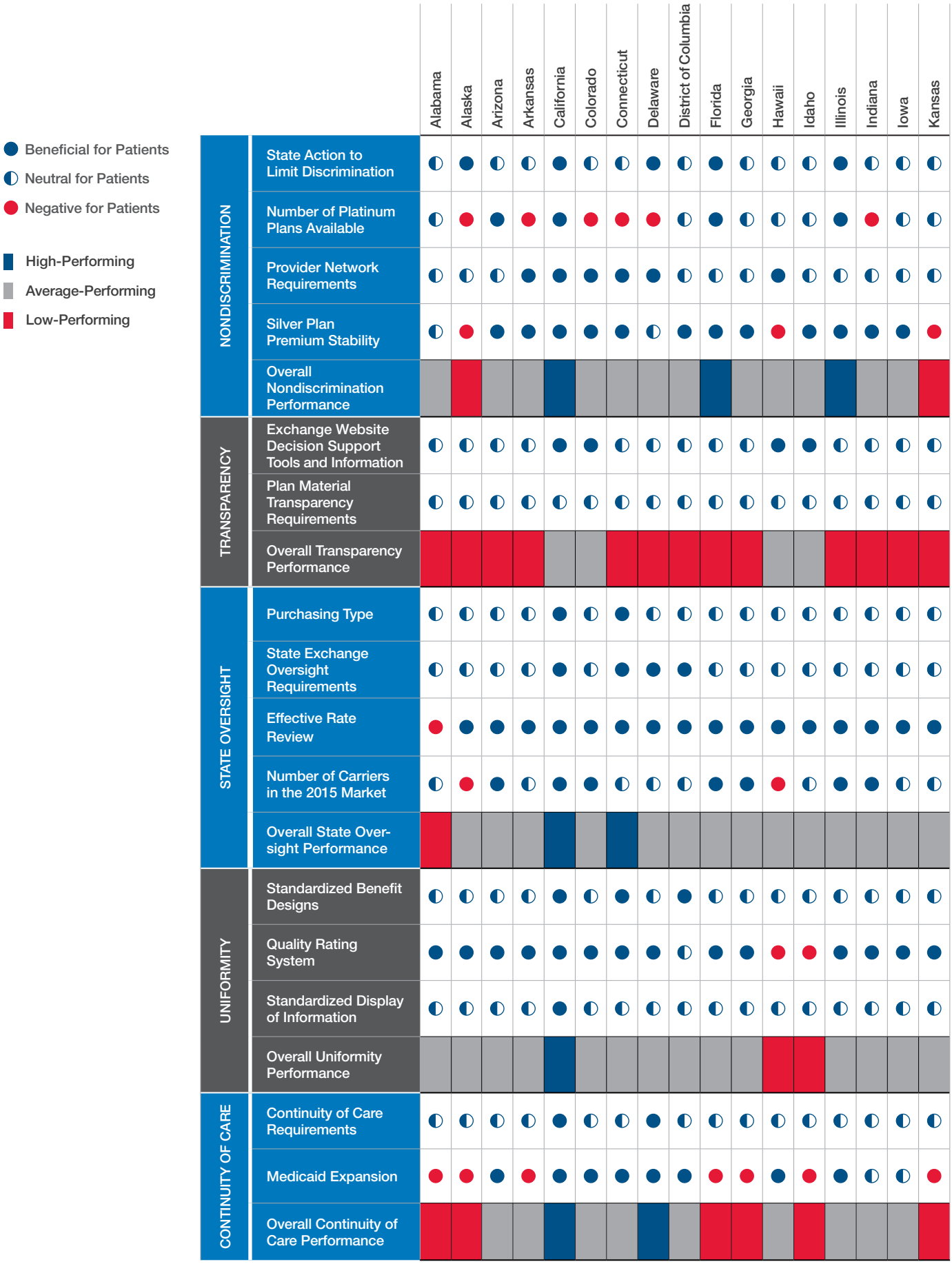

## Advance Patient Tools that Improve Transparency

Tools that increase transparency into the coverage and costs of exchange plans or offer decision support mechanisms can improve the plan selection process for people shopping for coverage in exchange plans. The cost to develop effective decision support tools may be prohibitive to many SBEs, and some states may to need to rely on federal tools, when and if they are developed.

A more attainable option for many states might be requirements that improve the transparency of plan information. The NHC's recent survey indicated that most patients felt they did not have all the information they needed to choose a health plan. Further, 36% of exchange enrollees had a hard time finding a list of providers and 38% had difficulty accessing plan formularies.[2] Even without large-scale, decision support tools, states can make small improvements to transparency standards that go a long way to helping people enroll in plans that meet their health and budget needs.

2 Navigating the ACA among Enrollees with Chronic Illnesses," Celinda Lake, March 2015.

# State-by-State
# Patient-Centeredness Data


Beneficial for Patients
Neutral for Patients
Negative for Patients
High-Performing
Average-Performing
Low-Performing
Alabama
Alaska
Arizona
Arkansas
California
Colorado
Connecticut
Delaware
District of Columbia
Florida
Georgia
Hawaii
Idaho
Illinois
Indiana
Iowa
Kansas
NONDISCRIMINATION
State Action to Limit Discrimination
Number of Platinum Plans Available
Provider Network Requirements
Silver Plan Premium Stability
Overall Nondiscrimination Performance
TRANSPARENCY
Exchange Website Decision Support Tools and Information
Plan Material Transparency Requirements
Overall Transparency Performance
STATE OVERSIGHT
Purchasing Type
State Exchange Oversight Requirements
Effective Rate Review
Number of Carriers in the 2015 Market
Overall State Oversight Performance
UNIFORMITY
Standardized Benefit Designs
Quality Rating System
Standardized Display of Information
Overall Uniformity Performance
CONTINUITY OF CARE
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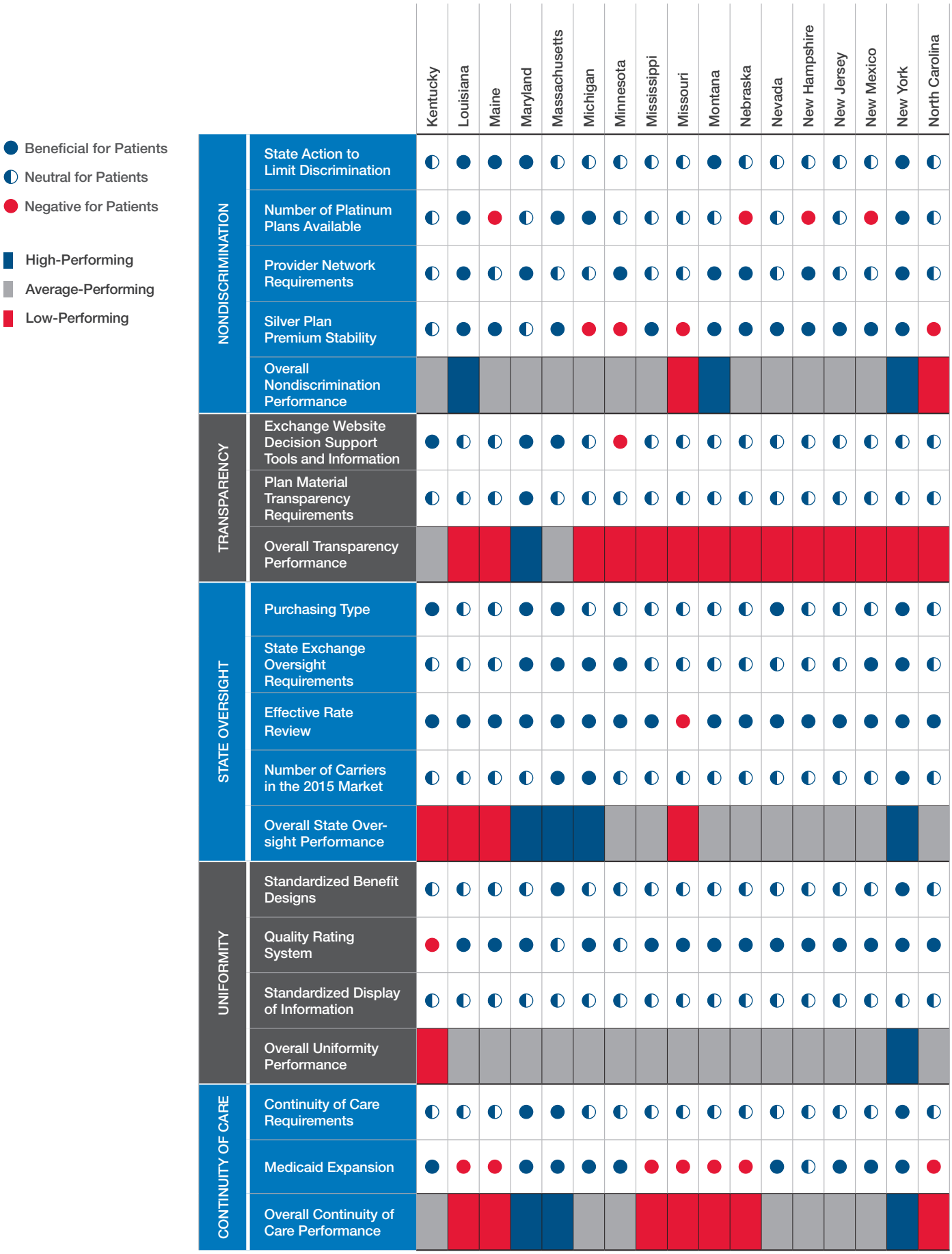
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Kentucky
Louisiana
Maine
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Michigan
Minnesota
Mississippi
Missouri
Montana
Nebraska
Nevada
New Hampshire
New Jersey
New Mexico
New York
North Carolina
NONDISCRIMINATION
State Action to Limit Discrimination
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Provider Network Requirements
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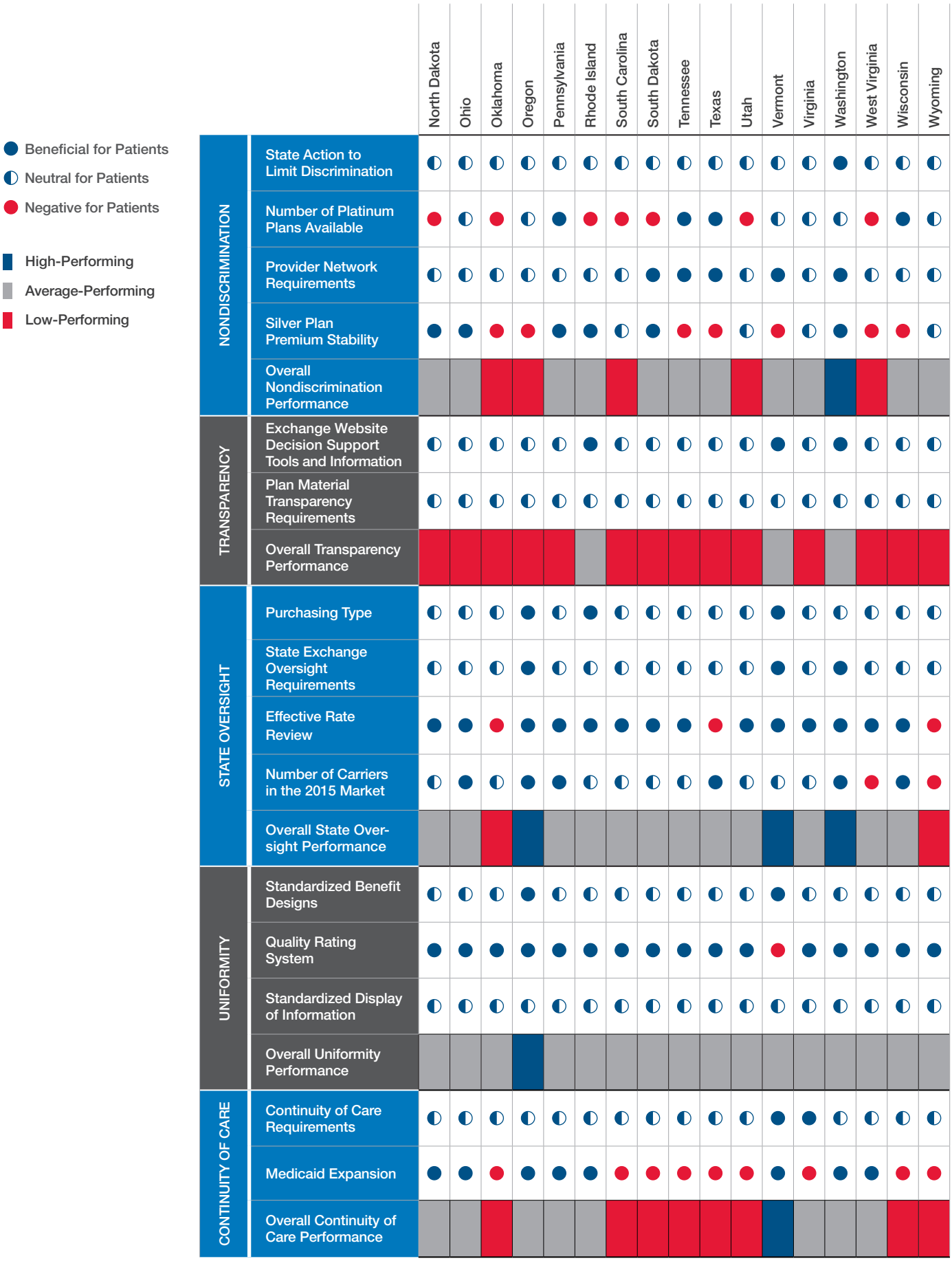
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Medicaid Expansion
Overall Continuity of Care Performance

# State-by-State
# **Progress Reports**

State Actions Protecting Patients in the Exchange

# Alabama Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- Four unique platinum offerings in the 2015 exchange.
- No state action on provider network requirements.
- The premium for the 2nd lowest cost silver plan is 3% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Alabama is an

Average-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Alabama is a

Low-Performing State

### ALABAMA HIGHLIGHTS

Alabama's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 97,900 Alabamians selected an exchange plan through HealthCare.gov. About 22% of Alabama residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Alabama has not expanded Medicaid.

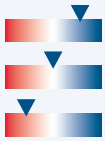
### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



- High-Performing
- Average-Performing
- Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Alabama does not have an effective rate review program.[3]
- Three carriers in the 2015 exchange market.

For state-oversight metrics, relative to other states, Alabama is a

Low-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Alabama is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Alabama has not expanded Medicaid, which would provide coverage for an estimated 272,000 people in the state.[5]

For continuity-of-care metrics, relative to other states, Alabama is a

Low-Performing State

## A MORE PATIENT-FOCUSED ALABAMA MARKETPLACE

Alabama has not exercised its full authority to regulate the exchange to promote patient protections. Alabama's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Alabama would have more control over exchange plans if the state opted to create a state-based exchange or, as an intermediary step, a partnership or exchange plan management model. Alabama has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Alabama also could become an active purchaser, which could help the state better manage increasing premiums.

Another critical step towards a patient-friendly health insurance market would be for Alabama to expand Medicaid. Expansion of Medicaid would provide health insurance for more than 272,000 Alabamians.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

For definitions of key terms, see the National Health Council's Putting Patients First® glossary.

1 Kaiser Family Foundation, "Estimated Number of Individuals Eligible for Financial Assistance through the Marketplaces," November, 2014, accessed via: http://kff.org/other/state-indicator/estimated-number-of-individuals-eligible-for-premium-tax-credits-through-the-marketplaces/

2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

5 Kaiser Family Foundation, "A Closer Look at the Impact of State Decisions Not to Expand Medicaid Coverage for Uninsured Adults," April 24, 2014, accessed via: http://kff.org/medicaid/fact-sheet/a-closer-look-at-the-impact-of-state-decisions-not-to-expand-medicaid-on-coverage-for-uninsured-adults/

# Alaska Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- Alaska enacted legislation requiring issuers to notify members at least 90 days before implementing cost sharing, deductibles, and copayments for certain categories of drugs (e.g., specialty medications) that exceed those for non-preferred brand drugs.
- Alaska has no platinum offerings in the 2015 exchange.
- No state action on provider network requirements.
- The premium for the 2nd lowest cost silver plan is 28% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Alaska is a

Low-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Alaska is a

Low-Performing State

### ALASKA HIGHLIGHTS

Alaska's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 12,900 Alaskans selected an exchange plan through HealthCare.gov. About 15% of Alaska residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Alaska has not expanded Medicaid.

### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.

High-Performing

Average-Performing

Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Two carriers in the 2015 exchange market.

For state-oversight metrics, relative to other states, Alaska is an

Average-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Alaska is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Alaska has not expanded Medicaid, which would provide coverage for an estimated 30,000 people in the state.[5]

For continutity-of-care metrics, relative to other states, Alaska is a

Low-Performing State

## A MORE PATIENT-FOCUSED ALASKA MARKETPLACE

Alaska has not exercised its full authority to regulate the exchange to promote patient protections. Alaska's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Alaska would have more control over exchange plans if the state opted to create a state-based exchange or a partnership exchange. Alaska has yet to establish exchange standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements. In addition, Alaska's exchange does not foster competition as there are only two carriers offering coverage. As a result, there are no platinum plans offered in the state, limiting options for the people who would benefit most—those with chronic conditions and disabilities. Under a different operational model, Alaska also could become an active purchaser, which could help the state better manage increasing premiums. Another critical step towards a patient-friendly health insurance market would be for Alaska to expand Medicaid. Expansion of Medicaid would provide health insurance for more than 30,000 Alaskans.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

For definitions of key terms, see the National Health Council's Putting Patients First® glossary.

1 Kaiser Family Foundation, "Estimated Number of Individuals Eligible for Financial Assistance through the Marketplaces," November, 2014, accessed via: http://kff.org/other/state-indicator/estimated-number-of-individuals-eligible-for-premium-tax-credits-through-the-marketplaces/

2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

5 Kaiser Family Foundation, "A Closer Look at the Impact of State Decisions Not to Expand Medicaid Coverage for Uninsured Adults," April 24, 2014, accessed via: http://kff.org/medicaid/fact-sheet/a-closer-look-at-the-impact-of-state-decisions-not-to-expand-medicaid-on-coverage-for-uninsured-adults/

# Arizona Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- ◐ No state action to limit discrimination.
- ● Seventeen unique platinum offerings in the 2015 exchange.
- ◐ No state action on provider network requirements.
- ● The premium for the 2nd lowest cost silver plan is 10% lower in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Arizona is an

Average-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- ◐ HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- ◐ No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Arizona is a

Low-Performing State

### ARIZONA HIGHLIGHTS

Arizona's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 120,100 Arizonans selected an exchange plan through HealthCare.gov. About 19% of Arizona residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Arizona expanded Medicaid, effective January 1, 2014.

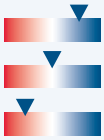
### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- ● Beneficial for Patients
- ◐ Neutral for Patients
- ● Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



- High-Performing
- Average-Performing
- Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Eleven carriers in the 2015 exchange market.

For state-oversight metrics, relative to other states, Arizona is an

Average-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Arizona is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Arizona expanded Medicaid, which now covers an estimated 299,000 people in the state.

For continutity-of-care metrics, relative to other states, Arizona is an

Average-Performing State

## A MORE PATIENT-FOCUSED ARIZONA MARKETPLACE

Arizona has not exercised its full authority to regulate the exchange to promote patient protections. Arizona's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Arizona would have more control over exchange plans if the state opted to create a state-based exchange or, as an intermediary step, a partnership or exchange plan management model. Arizona has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Arizona also could become an active purchaser.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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1 Kaiser Family Foundation, "Estimated Number of Individuals Eligible for Financial Assistance through the Marketplaces," November, 2014, accessed via: http://kff.org/other/state-indicator/estimated-number-of-individuals-eligible-for-premium-tax-credits-through-the-marketplaces/

2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

# Arkansas Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- No unique platinum offerings in the 2015 exchange.
- Arkansas enacted legislation requiring exchange plans to meet specified minimum network adequacy standards for primary care doctors, essential community providers, and specialists.
- The premium for the 2nd lowest cost silver plan is 2% lower in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Arkansas is an

Average-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Arkansas is a

Low-Performing State

### ARKANSAS HIGHLIGHTS

Arkansas established a state-federal partnership exchange. The state is responsible for managing plan participation and customer assistance in the exchange. Arkansas residents use the federal exchange, HealthCare.gov, to compare and purchase coverage.

In the 2014 plan year, 43,400 Arkansans selected an exchange plan through HealthCare.gov. About 17% of Arkansas residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Arkansas expanded Medicaid, effective in 2014.

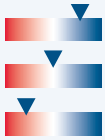
### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing
Average-Performing
Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Four carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Arkansas is an

Average-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Arkansas is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Arkansas has expanded Medicaid under a premium assistance model, which now covers an estimated 75,000 people in the state.

For continuity-of-care metrics, relative to other states, Arkansas is an

Average-Performing State

## A MORE PATIENT-FOCUSED ARKANSAS MARKETPLACE

Arkansas' partial reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Arkansas would have more control over exchange plans if the state opted to create a state-based exchange; currently, the state intends to run its own SHOP exchange in 2016 and its individual exchange in 2017.[5] Arkansas has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Arkansas also could become an active purchaser to have more authority over plan participation. Further, the state has no platinum plans, which limits options for the people who would benefit most—those with chronic conditions and disabilities. Contracting requirements could encourage, or potentially require, carriers to offer a platinum plan. As Arkansas implements the premium assistance model, the state should ensure the model preserves patient protections inherent in Medicaid.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

For definitions of key terms, see the National Health Council's Putting Patients First® glossary.

1 Kaiser Family Foundation, "Estimated Number of Individuals Eligible for Financial Assistance through the Marketplaces," November, 2014, accessed via: http://kff.org/other/state-indicator/estimated-number-of-individuals-eligible-for-premium-tax-credits-through-the-marketplaces/

2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

5 The Governor signed legislation delaying the state's plans to establish a state-based exchange until the Supreme Court rules on the legality of subsidies in federally-facilitated exchanges.

# California Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have taken extra steps to make their markets more patient-focused. This Progress Report measures a state across five principles to assess how well its insurance market is designed to meet the needs of people with chronic diseases and disabilities.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- California prohibits issuers from altering product benefit design from copayment to coinsurance or vice versa, or shifting product types (e.g., PPO, HMO).
- Sixteen unique platinum plans in the 2015 exchange.
- California enacted legislation increasing provider network adequacy and timely access to care, and prohibited plans from narrowing networks beyond normal network churn.
- The premium for the 2nd lowest cost silver plan is 1% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, California is a

High-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- California's website offers a cost calculator to help consumers estimate their annual medical spending for each plan offering. The enrollment portal allows consumers to filter plan options and has links to plans' provider directories and formularies. However, the website lacks formulary and provider search tools.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, California is an

Average-Performing State

### CALIFORNIA HIGHLIGHTS

California established a state-based exchange, called Covered California.

In the 2014 plan year, 1.2 million Californians selected an exchange plan through Covered California. About 37% of California residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

California expanded Medicaid, effective January 1, 2014.

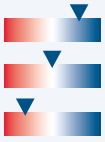
### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing
Average-Performing
Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Active purchasing—the state actively negotiates with plans to participate in the exchange.
- California requires multi-year contracts, limits the number of bids submitted by issuers, and requires plans to offer products in specific metals levels, including catastrophic plans.
- Its effective rate review program allows the state to manage premium increases.[3]
- Eleven carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, California is a

High-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- California standardized benefit designs.
- California rates exchange plans using a four-star quality rating system, derived from consumer survey results.
- California requires issuers to provide formularies online and update the information monthly. The state is developing a standard formulary template that will be implemented by January 1, 2017.

For uniformity metrics, relative to other states, California is a

High-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- California is awaiting approval to implement Bridge Plans, which aim to reduce the effects of churn between Medicaid and the exchange. The state also requires managed care plans to allow enrollees to continue seeing providers who have left their plan's network per the enrollee's request, for select conditions or services in a specific time frame.[4]
- California expanded Medicaid, which now covers an estimated 2,343,000 people in the state.

For continuity-of-care metrics, relative to other states, California is a

High-Performing State

## A MORE PATIENT-FOCUSED CALIFORNIA MARKETPLACE

California has achieved considerable success in fostering a patient-focused market, as they have taken numerous state actions, beyond the federal requirements, that better protect patients.

However, California has not exercised its full authority to regulate the exchange to promote patient protections. Notably, the state could enact contracting requirements to enhance plan information transparency. Though Covered California has an out-of-pocket calculator, it is limited in its ability to accurately assess estimated costs for patients. In order to best protect patients, California should develop a more robust and precise tool.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

# Colorado Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have taken extra steps to make their markets more patient-focused. This Progress Report measures a state across five principles to assess how well its insurance market is designed to meet the needs of people with chronic diseases and disabilities.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- Two unique platinum plans in the 2015 exchange.
- Colorado mandates that managed care plans have a provider network that is sufficient in numbers and types of providers to ensure timely access to care.
- The premium for the 2nd lowest cost silver plan is 16% lower in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Colorado is an

Average-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- Colorado's website has a formulary search tool to show whether each available plan covers specific drugs. The site has a provider search tool, a calculator to estimate tax credit amounts, access to plans' provider directories and formularies, as well as filters for search results.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Colorado is an

Average-Performing State

### COLORADO HIGHLIGHTS

Colorado established a state-based exchange, called Connect for Health Colorado.

In the 2014 plan year, 146,100 Coloradans selected an exchange plan through Connect for Health Colorado. About 25% of Colorado residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Colorado expanded Medicaid effective January 1, 2014.

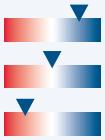
### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing

Average-Performing

Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Twelve carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Colorado is an

Average-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- Colorado rates exchange plans using a five-star quality score based customer surveys as well as clinical measures.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Colorado is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Colorado expanded Medicaid, which now covers an estimated 351,000 people in the state.

For continutity-of-care metrics, relative to other states, Colorado is an

Average-Performing State

## A MORE PATIENT-FOCUSED COLORADO MARKETPLACE

Colorado has achieved considerable success in fostering a patient-focused market, as they have taken numerous state actions, beyond the federal requirements, that better protect patients.

However, Colorado has not exercised its full authority to regulate the exchange to promote patient protections. Through legislative or other state action, Colorado could standardize benefit designs and plan benefit materials. The state also could consider oversight activities that would screen exchange plans for discrimination. The state has very few platinum plans, which limits options for the people who would benefit most—those with chronic conditions and disabilities. Contracting requirements could encourage, or potentially require, carriers to offer a platinum plan. Since it is a state-based exchange, Colorado could exert even more influence over the exchange by becoming an active purchaser.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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1 Kaiser Family Foundation, "Estimated Number of Individuals Eligible for Financial Assistance through the Marketplaces," November, 2014, accessed via: http://kff.org/other/state-indicator/estimated-number-of-individuals-eligible-for-premium-tax-credits-through-the-marketplaces/

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3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

# Connecticut Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have taken extra steps to make their markets more patient-focused. This Progress Report measures a state across five principles to assess how well its insurance market is designed to meet the needs of people with chronic diseases and disabilities.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- One unique platinum plan in the 2015 exchange.
- Connecticut requires exchange plans to have a provider network that is sufficient in numbers to ensure timely access to care.
- The premium for the 2nd lowest cost silver plan is 5% lower in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Connecticut is an

Average-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- The website allows consumers to filter plan offerings and has links to provider directories and formularies. The website lacks formulary and provider search tools and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Connecticut is a

Low-Performing State

### CONNECTICUT HIGHLIGHTS

Connecticut established a state-based exchange, called Access Health CT.

In the 2014 plan year, 74,300 Connecticut residents selected an exchange plan through Access Health CT. About 33% of Connecticut residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Connecticut expanded Medicaid, effective January 1, 2014.

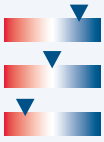
### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



- High-Performing
- Average-Performing
- Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Active purchasing—the state actively negotiates with plans to participate in the exchange.
- Connecticut requires multi-year contracts, limits the number of bids submitted by issuers, requires plans to offer products in specific metals levels, and requires plans by a single issuer to have distinct differences.
- Its effective rate review program allows the state to manage premium increases.[3]
- Six carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Connecticut is a

High-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- Connecticut standardized benefit designs.
- Connecticut rates exchange plans using a four-star quality rating system based on measures from the National Committee for Quality Assurance.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Connecticut is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Connecticut expanded Medicaid.

For continuity-of-care metrics, relative to other states, Michigan is an

Average-Performing State

## A MORE PATIENT-FOCUSED CONNECTICUT MARKETPLACE

Connecticut has achieved some success in fostering a patient-focused market, as they have taken several state actions, beyond the federal requirements, that better protect patients.

However, Connecticut has not exercised its full authority to regulate the exchange to promote patient protections. Through legislative or other state action, Connecticut could standardize plan benefit materials and enhance transparency of plan documents. Patients would also benefit from the development of an out-of-pocket calculator to estimate health expenses and better inform plan selection.

The state has very few platinum plans, which limits options for the people who would benefit most—those with chronic conditions and disabilities. Additional contracting requirements could encourage, or potentially require, carriers to offer a platinum plan.

Finally, Connecticut could take actions to establish continuity-of-care requirements to help patients maintain access to care.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

For definitions of key terms, see the National Health Council's Putting Patients First® glossary.

1 Kaiser Family Foundation, "Estimated Number of Individuals Eligible for Financial Assistance through the Marketplaces," November, 2014, accessed via: http://kff.org/other/state-indicator/estimated-number-of-individuals-eligible-for-premium-tax-credits-through-the-marketplaces/

2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

# Delaware Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- Delaware enacted legislation capping patient cost sharing for specialty tier drugs. The legislation also prohibits issuers from placing all drugs in a given class of drugs on a specialty tier.
- One unique platinum plan in the 2015 exchange.
- Delaware mandates that all plans sold in the exchange must have at least one full-time equivalent primary care provider for every 2,000 patients.
- The premium for the 2nd lowest cost silver plan is 4% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Delaware is an

Average-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Delaware is a

Low-Performing State

### DELAWARE HIGHLIGHTS

Delaware established a state-federal partnership exchange. The state is responsible for managing plan participation and customer assistance in the exchange. Delaware residents use the federal exchange, HealthCare.gov, to compare and purchase coverage.

In the 2014 plan year, 14,100 Delawareans selected an exchange plan through HealthCare.gov. About 29% of Delaware residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Delaware expanded Medicaid, effective in 2014.

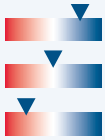
### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing

Average-Performing

Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- Delaware requires plans to offer products in specific metals levels, including bronze plans.
- Its effective rate review program allows the state to manage premium increases.[3]
- Three carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Delaware is an

Average-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Delaware is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- Health plans in 2015 must have transition policies in place for individuals who become eligible or lose eligibility for public programs, including those transitioning into exchange health plans from Medicaid. Policies must include a 60-day transition period for prescriptions, and a 90-day transition period for medical conditions and pre-authorized treatments.
- Delaware expanded Medicaid, which now covers an estimated 12,000 people in the state.

For continuity-of-care metrics, relative to other states, Delaware is a

High-Performing State

## A MORE PATIENT-FOCUSED DELAWARE MARKETPLACE

Delaware's partial reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Delaware would have more control over exchange plans if the state opted to create a state-based exchange. Delaware has yet to establish standards that would increase transparency or uniformity and protect patients from discrimination. The state has very few platinum plans, which limits options for the people who would benefit most—those with chronic conditions and disabilities. Contracting requirements could encourage, or potentially require, carriers to offer a platinum plan. Additionally, under a different operational model, Delaware could also become an active purchaser to have more authority over plan participation and better manage increasing premiums.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

# District of Columbia Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- ◐ No state action to limit discrimination.
- ◐ Three unique platinum offerings in the 2015 exchange.
- ◐ No action on provider network requirements.
- ● The premium for the 2nd lowest cost silver plan is less than 1% lower in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, DC is an

Average-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- ◐ DC's website allows consumers to filter plan options and has links to plans' provider directories. However, the website lacks links to plans' formularies, formulary and provider search tools, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- ◐ No action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, DC is a

Low-Performing State

### DC HIGHLIGHTS

DC established a state-based exchange, called DC Health Link.

In the 2014 plan year, 19,500 DC residents selected an exchange plan through DC Health Link. About 59% of DC residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

DC expanded Medicaid, effective in 2014.

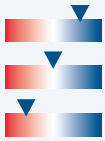
### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- ● Beneficial for Patients
- ◐ Neutral for Patients
- ● Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing
Average-Performing
Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the district does not actively negotiate with plans to participate in the exchange.
- DC requires plans to offer products in specific metal levels, including bronze plans, and ties participation outside and inside of the exchange.
- Its effective rate review program allows the state to manage premium increases.[3]
- Four carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, DC is an

Average-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- DC will require standardized benefit designs beginning in 2016.
- DC expressed interest in developing quality reporting requirements for the 2016 plan year.
- No action on standardized display of plan information.

For uniformity metrics, relative to other states, DC is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No action on continuity-of-care requirements.[4]
- DC expanded Medicaid, which now covers an estimated 20,000 people in the state.

For continuity-of-care metrics, relative to other states, DC is an

Average-Performing State

## A MORE PATIENT-FOCUSED DC MARKETPLACE

DC has achieved some success in fostering a patient-focused market, as they have taken several state actions, beyond the federal requirements, that better protect patients.

However, DC has not exercised its full authority to regulate the exchange to promote patient protections. Through legislative or other action, DC could improve plan information transparency or standardize plan benefit materials. Patients would benefit from the development of quality rating measures to better inform plan selection and oversight activities that would screen exchange plans for discriminatory benefits. As a state-based exchange, DC could exert even more influence over the exchange by becoming an active purchaser. DC could also consider instituting continuity-of-care requirements to ensure that patients have stable access to care. Furthermore, DC's exchange website should include links to formularies, and tools such as formulary and provider search tools.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

# Florida Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have taken extra steps to make their markets more patient-focused. This Progress Report measures a state across five principles to assess how well its insurance market is designed to meet the needs of people with chronic diseases and disabilities.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- In 2014, Florida enacted legislation to prohibit unfair methods of competition or deceptive acts to advertise insurance policies. Plans may not misrepresent the benefits, conditions, or terms of any insurance policy.
- Twenty-eight unique platinum offerings in the 2015 exchange.
- No state action on provider network requirements.
- The premium for the 2nd lowest cost silver plan is 2% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Florida is a

High-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Florida is a

Low-Performing State

### FLORIDA HIGHLIGHTS

Florida's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 983,800 Floridians selected an exchange plan through HealthCare.gov. About 39% of Florida residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Florida has not expanded Medicaid.

### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.

- High-Performing
- Average-Performing
- Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Twelve carriers in the 2015 exchange market.

For state-oversight metrics, relative to other states, Florida is an

Average-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Florida is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Florida has not expanded Medicaid, which would provide coverage for an estimated 1,212,000 people in the state.[5]

For continutity-of-care metrics, relative to other states, Florida is a

Low-Performing State

## A MORE PATIENT-FOCUSED FLORIDA MARKETPLACE

Florida's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Florida would have more control over exchange plans if the state opted to create a state-based exchange or, as an intermediary step, a partnership or exchange plan management model. Florida has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Florida also could become an active purchaser. Another critical step towards a patient-friendly health insurance market would be for Florida to expand Medicaid. The state legislature has debated the issue but never approved it. Expansion of Medicaid would provide health insurance for nearly 1.2 million Floridians.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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# Georgia Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have taken extra steps to make their markets more patient-focused. This Progress Report measures a state across five principles to assess how well its insurance market is designed to meet the needs of people with chronic diseases and disabilities.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- ◐ No state action to limit discrimination.
- ◐ Seven unique platinum offerings in the 2015 exchange.
- ◐ No state action on provider network requirements.
- ● The premium for the 2nd lowest cost silver plan is 2% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Georgia is an

Average-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- ◐ HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- ◐ No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Georgia is a

Low-Performing State

### GEORGIA HIGHLIGHTS

Georgia's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 316,500 Georgians selected an exchange plan through HealthCare.gov. About 29% of Georgia residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Georgia has not expanded Medicaid.

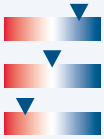
### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- ● Beneficial for Patients
- ◐ Neutral for Patients
- ● Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



- High-Performing
- Average-Performing
- Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Ten carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Georgia is an

Average-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Georgia is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Georgia has not expanded Medicaid, which would provide coverage for an estimated 599,000 people in the state.[5]

For continutity-of-care metrics, relative to other states, Georgia is a

Low-Performing State

## A MORE PATIENT-FOCUSED GEORGIA MARKETPLACE

Georgia's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Georgia would have more control over exchange plans if the state opted to create a state-based exchange or, as an intermediary step, a partnership or exchange plan management model. Georgia has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Georgia also could become an active purchaser. Another critical step towards a patient-friendly health insurance market would be for Georgia to expand Medicaid. Expansion of Medicaid would provide health insurance for nearly 600,000 Georgians.

## METHODOLOGY

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# Hawaii Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- Four unique platinum offerings in the 2015 exchange.
- Hawaii enacted legislation requiring the Insurance Commissioner to provide the Hawaii Health Connector with a list of qualified health plans that meet network adequacy standards (as determined by the Commissioner).
- The premium for the 2nd lowest cost silver plan is 9% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Hawaii is an

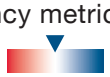
Average-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- Hawaii's website offers a provider search tool, and allows consumers to filter plan options. Additionally, the website has links to plans' provider directories and formularies. However, the website lacks a formulary search tool and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Hawaii is an



Average-Performing State

### HAWAII HIGHLIGHTS

Hawaii established a state-based exchange, called the Hawaii Health Connector.

In the 2014 plan year, 9,700 Hawaiians selected an exchange plan through Hawaii Health Connector. About 18% of Hawaii residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Hawaii expanded Medicaid, effective January 1, 2014.

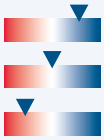
### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing

Average-Performing

Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Two carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Hawaii is an

Average-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- Hawaii does not currently have a quality rating system in place for the 2015 plan year, and there are no details available on plans to develop a quality rating system.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Hawaii is a

Low-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Hawaii expanded Medicaid, which now covers an estimated 10,000 people in the state.

For continutity-of-care metrics, relative to other states, Hawaii is an

Average-Performing State

## A MORE PATIENT-FOCUSED HAWAII MARKETPLACE

Hawaii has achieved some success in fostering a patient-focused market, as they have taken several state actions, beyond the federal requirements, that better protect patients.

However, Hawaii has not exercised its full authority to regulate the exchange to promote patient protections. Through legislative or other state action, Hawaii could standardize plan benefit materials and enhance transparency of plan documents. Patients would also benefit from the development of quality rating measures as well as an out-of-pocket calculator to estimate health expenses and better inform plan selection. In addition, Hawaii's exchange does not foster competition as there are only two carriers offering coverage. As a result of the lack of competition, there are few platinum plans offered in the state, limiting options for the people who would benefit most—those with chronic conditions and disabilities. Furthermore, Hawaii could take actions to establish continuity-of-care requirements to help patients maintain access to care.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

For definitions of key terms, see the National Health Council's Putting Patients First® glossary.

1 Kaiser Family Foundation, "Estimated Number of Individuals Eligible for Financial Assistance through the Marketplaces," November, 2014, accessed via: http://kff.org/other/state-indicator/estimated-number-of-individuals-eligible-for-premium-tax-credits-through-the-marketplaces/

2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

# Idaho Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- ◐ No state action to limit discrimination.
- ◐ Three unique platinum offerings in the 2015 exchange.
- ◐ No state action on provider network requirements.
- ● The premium for the 2nd lowest cost silver plan is 9% lower in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Idaho is an

Average-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- ● Idaho's website allows consumers to filter plan options, and has links to plans' provider directories and formularies. The website also has a calculator to help patients estimate out-of-pocket spending amounts. However, the website lacks formulary and provider search tools.
- ◐ No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Idaho is an

Average-Performing State

### IDAHO HIGHLIGHTS

For 2015, Idaho established a state-based exchange, called Your Health Idaho. In 2014, Idaho operated as a state-run exchange using the HealthCare.gov platform.

In the 2014 plan year, 76,100 Idahoans selected an exchange plan through HealthCare.gov. About 35% of Idaho residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Idaho has not expanded Medicaid.

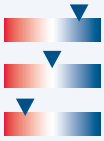
### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- ● Beneficial for Patients
- ◐ Neutral for Patients
- ● Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing
Average-Performing
Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Five carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Idaho is an

Average-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- Idaho does not currently have a quality rating system in place for the 2015 plan year, and there are no details available on plans to develop a quality rating system.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Idaho is a

Low-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Idaho has not expanded Medicaid, which would provide coverage for an estimated 86,000 people in the state.[5]

For continutity-of-care metrics, relative to other states, Idaho is a

Low-Performing State

## A MORE PATIENT-FOCUSED IDAHO MARKETPLACE

Idaho has achieved some success in fostering a patient-focused market, as they have taken several state actions, beyond the federal requirements, that better protect patients.

However, Idaho has not exercised its full authority to regulate the exchange to promote patient protections. Through legislative or other state action, Idaho could standardize plan benefit materials, and enhance transparency of plan documents. Idaho should also work to develop tools for patients to use on the website that increase transparency to better inform plan selection. Idaho also could take actions to establish continuity-of-care requirements to help patients maintain access to care. Another critical step towards a patient-friendly health insurance market would be for Idaho to expand Medicaid. Expansion of Medicaid would provide health insurance for more than 86,000 Idahoans.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

5 Kaiser Family Foundation, "A Closer Look at the Impact of State Decisions Not to Expand Medicaid Coverage for Uninsured Adults," April 24, 2014, accessed via: http://kff.org/medicaid/fact-sheet/a-closer-look-at-the-impact-of-state-decisions-not-to-expand-medicaid-on-coverage-for-uninsured-adults/

# Illinois Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have taken extra steps to make their markets more patient-focused. This Progress Report measures a state across five principles to assess how well its insurance market is designed to meet the needs of people with chronic diseases and disabilities.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- The Illinois Department of Insurance (DOI) created non–discrimination polices to protect people with HIV/AIDS. Issuers must cover all HIV/AIDS medicines the government considers "recommended" or "alternative" drug regimens. Issuers also cannot impose unreasonable step therapy requirements to recommended or alternative regimens designated by the government.
- Seventeen unique platinum offerings in the 2015 exchange.
- No state action on provider network requirements.
- The premium for the 2nd lowest cost silver plan is 2% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Illinois is a

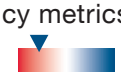
High-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Illinois is a



Low-Performing State

### ILLINOIS HIGHLIGHTS

Illinois established a state-federal partnership exchange. Illinois manages plan participation, customer assistance, and operates the consumer assistance web-portal Get Covered Illinois. Illinois residents must use the federal exchange, HealthCare.gov, to enroll in coverage.

In the 2014 plan year, 217,500 Illinoisans selected an exchange plan through HealthCare.gov. About 23% of Illinois residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Illinois expanded Medicaid, effective January 1, 2014.

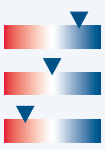
### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing
Average-Performing
Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contraction requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Eleven carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Illinois is an

Average-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Illinois is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Illinois has expanded Medicaid, which now covers an estimated 418,000 people in the state.

For continutity-of-care metrics, relative to other states, Illinois is an

Average-Performing State

## A MORE PATIENT-FOCUSED ILLINOIS MARKETPLACE

Illinois has achieved some success in fostering a patient-focused market, as they have taken numerous state actions, beyond the federal requirements, that better protect patients. However, Illinois's partial reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Illinois would have more control over exchange plans if the state opted to create a state-based exchange. Illinois has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination that encompasses more conditions than just HIV/AIDS, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Illinois also could become an active purchaser to better manage exchange plan participation.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

# Indiana Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- One unique platinum offering in the 2015 exchange.
- No state action on provider network requirements.
- The premium for the 2nd lowest cost silver plan is 7% lower in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Indiana is an

Average-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Indiana is a

Low-Performing State

### INDIANA HIGHLIGHTS

Indiana's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 132,400 Hoosiers selected an exchange plan through HealthCare.gov. About 26% of Indiana residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Indiana expanded Medicaid, effective February 1, 2015.

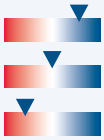
### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



- High-Performing
- Average-Performing
- Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Ten carriers in the 2015 exchange market.

For state-oversight metrics, relative to other states, Indiana is an

Average-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Indiana is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Indiana expanded Medicaid via a waiver model that requires some beneficaires to make monthly contributions. The program covers an estimated 79,000 people in the state.

For continutity-of-care metrics, relative to other states, Indiana is an

Average-Performing State

## A MORE PATIENT-FOCUSED INDIANA MARKETPLACE

Indiana has not exercised its full authority to regulate the exchange to promote patient protections. Indiana's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Indiana would have more control over exchange plans if the state opted to create a state-based exchange or, as an intermediary step, a partnership or exchange plan management model. Indiana has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. In addition, the state has very few platinum plans, which limits options for the people who would benefit most—those with chronic conditions and disabilities. Under a different operational model, Indiana also could become an active purchaser. As Indiana implements the waiver program, the state should ensure the program preserves patient protections inherent in Medicaid.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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# Iowa Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have taken extra steps to make their markets more patient-focused. This Progress Report measures a state across five principles to assess how well its insurance market is designed to meet the needs of people with chronic diseases and disabilities.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- ◐ No state action to limit discrimination.
- ◐ Three unique platinum offerings in the 2015 exchange.
- ◐ No state action on provider network requirements.
- ● The premium for the 2nd lowest cost silver plan is 4% lower in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Iowa is an

Average-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- ◐ HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- ◐ No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Iowa is a

Low-Performing State

### IOWA HIGHLIGHTS

Iowa established a state-federal partnership exchange. The state is responsible for managing plan participation and customer assistance in the exchange. Iowa residents use the federal exchange, Healthcare.gov, to compare and purchase coverage.

In the 2014 plan year, 29,200 Iowans selected an exchange plan through Healthcare.gov. About 13% of Iowa residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Iowa expanded Medicaid effective January 1, 2014. Iowa did not expand the traditional Medicaid program but used a waiver to enroll most newly eligible beneficiaries in the exchange and provide assistance paying monthly premiums.

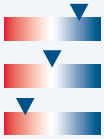
### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- ● Beneficial for Patients
- ◐ Neutral for Patients
- ● Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing

Average-Performing

Low-Performing

NATIONAL HEALTH COUNCIL

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Three carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Iowa is an

Average-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Iowa is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Iowa has expanded Medicaid under a premium assistance model, which now covers an estimated 75,000 people in the state.

For continutity-of-care metrics, relative to other states, Iowa is an

Average-Performing State

## A MORE PATIENT-FOCUSED IOWA MARKETPLACE

Iowa's partial reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Iowa would have more control over exchange plans if the state opted to create a state-based exchange. Iowa has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Iowa also could become an active purchaser to have more authority over plan participation. As Iowa implements the premium assistance model, the state should ensure the model preserves patient protections inherent in Medicaid.

## METHODOLOGY

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2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

# Kansas Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- Two unique platinum offerings in the 2015 exchange.
- No state action on provider network requirements.
- The premium for the 2nd lowest cost silver plan is 10% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Kansas is a

Low-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Kansas is a

Low-Performing State

### KANSAS HIGHLIGHTS

Kansas's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 57,000 Kansans selected an exchange plan through HealthCare.gov. About 23% of Kansas residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Kansas has not expanded Medicaid.

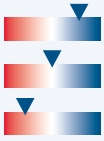
### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing

Average-Performing

Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Four carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Kansas is an

Average-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Kansas is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements. [4]
- Kansas has not expanded Medicaid, which would provide coverage for an estimated 126,000 people in the state.[5]

For continutity-of-care metrics, relative to other states, Kansas is a

Low-Performing State

## A MORE PATIENT-FOCUSED KANSAS MARKETPLACE

Kansas has not exercised its full authority to regulate the exchange to promote patient protections. Kansas' reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Kansas would have more control over exchange plans if the state opted to create a state-based exchange. Kansas has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements. Under a different operational model, Kansas also could become an active purchaser, which could help the state better manage increasing premiums. In addition, the state has very few platinum plans, which limits options for the people who would benefit most—those with chronic conditions and disabilities. Another critical step towards a patient-friendly health insurance market would be for Kansas to expand Medicaid. Expansion of Medicaid would provide health insurance for more than 126,000 Kansans.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

For definitions of key terms, see the National Health Council's Putting Patients First® glossary.

1 Kaiser Family Foundation, "Estimated Number of Individuals Eligible for Financial Assistance through the Marketplaces," November, 2014, accessed via: http://kff.org/other/state-indicator/estimated-number-of-individuals-eligible-for-premium-tax-credits-through-the-marketplaces/

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5 Kaiser Family Foundation, "A Closer Look at the Impact of State Decisions Not to Expand Medicaid Coverage for Uninsured Adults," April 24, 2014, accessed via: http://kff.org/medicaid/fact-sheet/a-closer-look-at-the-impact-of-state-decisions-not-to-expand-medicaid-on-coverage-for-uninsured-adults/

# Kentucky Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- Two unique platinum plans in the 2015 exchange.
- No state action on provider network requirements.
- The premium for the 2nd lowest cost silver plan is 3% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Kentucky is an

Average-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- Kentucky's website has a provider search tool, a calculator to estimate tax credit amounts, links to plans' provider directories and formularies, and allows consumers to filter plan options. The website lacks a formulary search tool.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Kentucky is an

Average-Performing State

### KENTUCKY HIGHLIGHTS

Kentucky established a state-based exchange, called Kynect.

In the 2014 plan year, 83,000 Kentuckians selected an exchange plan through Kynect. About 32% of Kentucky residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Kentucky expanded Medicaid, effective in 2014.

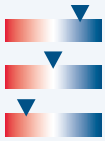
### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



- High-Performing
- Average-Performing
- Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Active purchasing—the state actively negotiates with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Eight carriers in the 2015 exchange market.

For state-oversight metrics, relative to other states, Kentucky is an

Average-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- Kentucky does not currently have a quality rating system in place for the 2015 plan year, and there are no details available on plans to develop a quality rating system.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Kentucky is a

Low-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Kentucky expanded Medicaid, which now covers an estimated 467,000 people in the state.

For continuity-of-care metrics, relative to other states, Kentucky is an

Average-Performing State

## A MORE PATIENT-FOCUSED KENTUCKY MARKETPLACE

Kentucky has achieved considerable success in fostering a patient-focused market, as they have taken numerous state actions, beyond the federal requirements, that better protect patients.

However, Kentucky has not exercised its full authority to regulate the exchange to promote patient protections. Through legislative or other state action, Kentucky could standardize benefit designs or plan benefit materials, as well as require more robust provider networks. Patients would benefit from the development of quality rating measures to better inform plan selection. The state also could consider oversight activities that would screen exchange plans for discrimination and enhance transparency of plan documents. Additionally, there are few platinum plans offered in the state, limiting options for the people who would benefit most—those with chronic conditions and disabilities. Furthermore, Kentucky could take actions to establish continuity-of-care requirements to help patients maintain access to care.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

# Louisiana Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- Louisiana enacted legislation capping patient cost sharing at $150 per month for specialty tier drugs. The legislation also requires issuers with a specialty drug tier to create an exceptions process for enrollees.
- Twelve unique platinum offerings in the 2015 exchange.
- Issuers must maintain a network that is sufficient in numbers and types of health care providers to ensure that enrollees have access to health care services without unreasonable delay.
- The premium for the 2nd lowest cost silver plan is 5% lower in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Louisiana is a

High-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Louisiana is a

Low-Performing State

### LOUISIANA HIGHLIGHTS

Louisiana's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 101,800 Louisianans selected an exchange plan through HealthCare.gov. About 19% of Louisiana residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Louisiana has not expanded Medicaid.

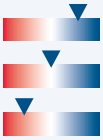
### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing
Average-Performing
Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Six carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Louisiana is an

Average-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Louisiana is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Louisiana has not expanded Medicaid, which would provide coverage for an estimated 364,000 people in the state.[5]

For continuity-of-care metrics, relative to other states, Louisiana is a

Low-Performing State

## A MORE PATIENT-FOCUSED LOUISIANA MARKETPLACE

Louisiana has not exercised its full authority to regulate the exchange to promote patient protections. Louisiana's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Louisiana would have more control over exchange plans if the state opted to create a state-based exchange or, as an intermediary step, a partnership or exchange plan management model. Louisiana has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Louisiana could also become an active purchaser. Another critical step towards a patient-friendly health insurance market would be for Louisiana to expand Medicaid. Expansion of Medicaid would provide health insurance for more than 364,000 Louisianans.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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# Maine Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- Maine enacted legislation limiting out-of-pocket spending for prescription drugs subject to coinsurance to $3,500 per year.
- No unique platinum offerings in the 2015 exchange.
- No state action on provider network requirements.
- The premium for the 2nd lowest cost silver plan is 4% lower in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Maine is an

Average-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Maine is a

Low-Performing State

### MAINE HIGHLIGHTS

Maine's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 44,300 Mainers selected an exchange plan through HealthCare.gov. About 36% of Maine residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Maine has not expanded Medicaid.

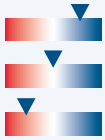
### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing
Average-Performing
Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Four carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Maine is an

Average-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Maine is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Maine has not expanded Medicaid, which would provide coverage for an estimated 38,000 people in the state.[5]

For continuity-of-care metrics, relative to other states, Maine is a

Low-Performing State

## A MORE PATIENT-FOCUSED MAINE MARKETPLACE

Maine has not exercised its full authority to regulate the exchange to promote patient protections. Maine's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Maine would have more control over exchange plans if the state opted to create a state-based exchange. Maine has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Further, the state has very few platinum plans, which limits options for the people who would benefit most—those with chronic conditions and disabilities. Contracting requirements could encourage, or potentially require, carriers to offer a platinum plan.

Another critical step towards a patient-friendly health insurance market would be for Maine to expand Medicaid. Expansion of Medicaid would provide health insurance for more than 38,000 residents.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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# Maryland Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have taken extra steps to make their markets more patient-focused. This Progress Report measures a state across five principles to assess how well its insurance market is designed to meet the needs of people with chronic diseases and disabilities.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- Maryland enacted legislation capping patient cost sharing for specialty tier drugs.
- Four unique platinum plans in the 2015 exchange.
- Maryland allows the state exchange to deny certification to health plans that do not meet the standards of network adequacy for the plan service area.
- The premium for the 2nd lowest cost silver plan is 3% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Maryland is an

Average-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- Maryland's exchange website has a provider search tool, access to plans' formularies, as well as filters for search results. The website lacks a formulary search tool and a calculator to help estimate tax credit or out of pocket amounts.
- Maryland requires plan formulary documents to list tiering and cost-sharing information. Also, plan filings to the Department of Insurance must indicate which drugs are covered under the medical benefit.

For transparency metrics, relative to other states, Maryland is a

High-Performing State

### MARYLAND HIGHLIGHTS

Maryland established a state-based exchange, called Maryland Health Connection.

In the 2014 plan year, 81,000 Marylanders selected an exchange plan through the Maryland Health Connection. About 18% of Maryland residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Maryland expanded Medicaid effective January 1, 2014.

### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.

High-Performing

Average-Performing

Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Active purchasing—the state actively negotiates with plans to participate in the exchange.
- Maryland requires health insurance companies to offer catastrophic coverage options and requires plans by a single issuer to have distinct differences.
- Its effective rate review program allows the state to manage premium increases.[3]
- Six carriers in the 2015 exchange market.

For state-oversight metrics, relative to other states, Maryland is a

High-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- Maryland rates exchange plans using a five-star quality score based on 2013 quality and performance data from the issuers' similar, off-exchange plans.
- No state action on standardized display of information.

For uniformity metrics, relative to other states, Maryland is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- Health plans in 2015 must allow new enrollees to receive care from their providers for certain conditions or services for a set amount of time, even if those providers are not in their new health plan's network. Plans must also notify new enrollees of these rights.[4]
- Maryland expanded Medicaid, which now covers an estimated 287,000 people in the state.

For continutity-of-care metrics, relative to other states, Maryland is a

High-Performing State

## A MORE PATIENT-FOCUSED MARYLAND MARKETPLACE

Maryland has achieved considerable success in fostering a patient-focused market, as they have taken numerous state actions, beyond the federal requirements, that better protect patients.

However, Maryland has not exercised its full authority to regulate the exchange market to promote patient protections. Through legislative or other state action, Maryland could standardize benefit designs to better manage patients' out-of-pocket expenses. The state has few platinum plans, which limits options for the people who would benefit most—those with chronic conditions and disabilities. Maryland may want to further exercise its active purchasing power to increase competition in the exchange market and attract more health plans which can help to keep premiums stable from year to year.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

For definitions of key terms, see the National Health Council's Putting Patients First® glossary.

1 Kaiser Family Foundation, "Estimated Number of Individuals Eligible for Financial Assistance through the Marketplaces," November, 2014, accessed via: http://kff.org/other/state-indicator/estimated-number-of-individuals-eligible-for-premium-tax-credits-through-the-marketplaces/

2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

# Massachusetts Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- ◐ No state action to limit discrimination.
- ● Twenty-four unique platinum offerings in the 2015 exchange.
- ◐ No state action on provider network requirements.
- ● The premium for the 2nd lowest cost silver plan is 8% less in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Massachusetts is an

Average-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- ● Massachusetts' website allows consumers to filter plan options and has links to plans' provider directories and formularies. The website also features a provider search tool. However, the website lacks a formulary search tool and calculators to help estimate tax credit or out-of-pocket expense amounts.
- ◐ No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Massachusetts is an

Average-Performing State

### MASSACHUSETTS HIGHLIGHTS

Massachusetts established a state-based exchange, called the Massachusetts Health Connector.

In the 2014 plan year, 31,700 residents in Massachusetts selected an exchange plan through the Health Connector. About 8% of Massachusetts residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Massachusetts expanded Medicaid, effective in 2014.

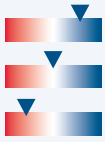
### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- ● Beneficial for Patients
- ◐ Neutral for Patients
- ● Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing
Average-Performing
Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Active purchasing—the state actively negotiates with plans to participate in the exchange.
- Massachusetts limits the number of bids an issuer may submit and requires issuers to offer plans in all four metal levels.
- Its effective rate review program allows the state to manage premium increases.[3]
- Twelve carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Massachusetts is a

High-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- Massachusetts standardized benefit designs.
- In 2014, the Massachusetts Health Connector developed quality ratings on a four-star scale based on the National Committee for Quality Assurance's plan report card, reflecting issuer evaluations from July 2013. However, in 2015 the ratings are no longer displayed. The Health Connector has not publicly made a rationale for the removal of ratings.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Massachusetts is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- Massachusetts provides supplemental premium subsidies for individuals with incomes below 300% of the federal poverty level.
- Massachusetts expanded Medicaid, which now covers an estimated 276,000 people in the state.

For continuity-of-care metrics, relative to other states, Massachusetts is a

High-Performing State

## A MORE PATIENT-FOCUSED MASSACHUSETTS MARKETPLACE

Massachusetts has achieved considerable success in fostering a patient-focused market, as they have taken numerous state actions, beyond the federal requirements, that better protect patients.

However, Massachusetts has not exercised its full authority to regulate the exchange to promote patient protections. Through legislative or other state action, Massachusetts could enhance contracting requirements for plan information transparency and standardize the display of plan information. The state also could consider oversight activities that would screen exchange plans for discrimination, and enhance network adequacy requirements. Further, patients would benefit if the state displayed quality rating measures, as these measures would better inform plan selection.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

# Michigan Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have taken extra steps to make their markets more patient-focused. This Progress Report measures a state across five principles to assess how well its insurance market is designed to meet the needs of people with chronic diseases and disabilities.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- Ten unique platinum offerings in the 2015 exchange.
- No state action on provider network requirements.
- The premium for the 2nd lowest cost silver plan is 5% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Michigan is an

Average-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Michigan is a

Low-Performing State

### MICHIGAN HIGHLIGHTS

Michigan's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 272,500 Michiganians selected an exchange plan through HealthCare.gov. About 40% of Michigan residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Michigan expanded Medicaid, effective April 1, 2014.

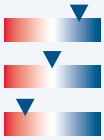
### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



- High-Performing
- Average-Performing
- Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- Michigan ties issuer participation inside and outside of the exchange.
- Its effective rate review program allows the state to manage premium increases.[3]
- Fifteen carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Michigan is a

High-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Michigan is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Michigan expanded Medicaid, which now covers an estimated 239,000 people.

For continuity-of-care metrics, relative to other states, Michigan is an

Average-Performing State

## A MORE PATIENT-FOCUSED MICHIGAN MARKETPLACE

Michigan has not exercised its full authority to regulate the exchange to promote patient protections. Michigan's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Mighigan would have more control over exchange plans if the state opted to create a state-based exchange or, as an intermediary step, a partnership or exchange plan management model. Michigan has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Michigan also could become an active purchaser to have more authority over plan participation. As Michigan implements the Medicaid waiver program, the state should ensure the waiver program preserves patient protections inherent in traditional Medicaid.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

# Minnesota Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- Four unique platinum plans in the 2015 exchange.
- Minnesota enacted legislation that set maximum travel distance and time from a patient to covered provider, to ensure reasonable access to care.
- The premium for the 2nd lowest cost silver plan is 19% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Minnesota is an

Average-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- Minnesota's website allows consumers to filter plan options. However the website lacks links to plans' provider directories and formularies, as well as formulary and provider search tools. The website also lacks calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Minnesota is a

Low-Performing State

### MINNESOTA HIGHLIGHTS

Minnesota established a state-based exchange, called MNSure.

In the 2014 plan year, 60,100 Minnesotans selected an exchange plan through MNSure. About 22% of Minnesota residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Minnesota expanded Medicaid, effective January 1, 2014.

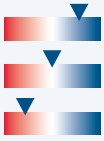
### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



- High-Performing
- Average-Performing
- Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- Minnesota ties issuer participation inside and outside of the exchange, and requires plans by a single issuer to have distinct differences.
- Its effective rate review program allows the state to manage premium increases.[3]
- Five carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Minnesota is an

Average-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- Minnesota formed an Exchange Measurement and Reporting Task Work group that examined proposed quality measures; however, no quality measures have been finalized.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Minnesota is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Minnesota expanded Medicaid, which now covers an estimated 301,000 people in the state.

For continutity-of-care metrics, relative to other states, Minnesota is an

Average-Performing State

## A MORE PATIENT-FOCUSED MINNESOTA MARKETPLACE

Minnesota has some success in fostering a patient-focused market, as they have taken several state actions, beyond the federal requirements, that better protect patients.

However, Minnesota has not exercised its full authority to regulate the exchange to promote patient protections. Through legislative or other state action, Minnesota could standardize benefit designs and plan benefit materials. Minnesota should also work to develop tools for patients to use on the website that increase transparency to better inform plan selection. Examples of tools to help transparency include: formulary and provider search tools, out-of-pocket calculators, as well as a quality rating system. The state also could consider oversight activities that better monitor exchange plans for discriminationary benefit designs. As a state-based exchange, Minnesota could exert even more influence over the exchange by becoming an active purchaser, which could help the state better manage increasing premiums.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

# Mississippi Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- ◐ No state action to limit discrimination.
- ◐ Three unique platinum offerings in the 2015 exchange.
- ◐ No state action on provider network requirements.
- ● The premium for the 2nd lowest cost silver plan is 26% lower in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Mississippi is an

Average-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- ◐ HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- ◐ No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Mississippi is a

Low-Performing State

### MISSISSIPPI HIGHLIGHTS

Mississippi's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 61,500 Mississippians selected an exchange plan through HealthCare.gov. About 22% of Mississippi residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Mississippi has not expanded Medicaid.

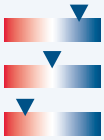
### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- ● Beneficial for Patients
- ◐ Neutral for Patients
- ● Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



- High-Performing
- Average-Performing
- Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Three carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Mississippi is an

Average-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Mississippi is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Mississippi has not expanded Medicaid, which would provide coverage for an estimated 203,000 people in the state.[5]

For continutity-of-care metrics, relative to other states, Mississippi is a

Low-Performing State

## A MORE PATIENT-FOCUSED MISSISSIPPI MARKETPLACE

Mississippi has not exercised its full authority to regulate the exchange to promote patient protections. Mississippi's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Mississippi would have more control over exchange plans if the state opted to create a state-based exchange or, as an intermediary step, a partnership or exchange plan management model. Mississippi has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Mississippi also could become an active purchaser. Another critical step towards a patient-friendly health insurance market would be for Mississippi to expand Medicaid. Expansion of Medicaid would provide health insurance for more than 203,000 Mississippians.

## METHODOLOGY

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4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

5 Kaiser Family Foundation, "A Closer Look at the Impact of State Decisions Not to Expand Medicaid Coverage for Uninsured Adults," April 24, 2014, accessed via: http://kff.org/medicaid/fact-sheet/a-closer-look-at-the-impact-of-state-decisions-not-to-expand-medicaid-on-coverage-for-uninsured-adults/

# Missouri Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- ◐ No state action to limit discrimination.
- ◐ Three unique platinum offerings in the 2015 exchange.
- ◐ No state action on provider network requirements.
- ● The premium for the 2nd lowest cost silver plan is 5% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Missouri is a

Low-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- ◐ HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- ◐ No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Missouri is a

Low-Performing State

### MISSOURI HIGHLIGHTS

Missouri's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 152,300 Missourians selected an exchange plan through HealthCare.gov. About 24% of Missouri residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Missouri has not expanded Medicaid.

### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- ● Beneficial for Patients
- ◐ Neutral for Patients
- ● Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.

High-Performing

Average-Performing

Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Missouri does not have an effective rate review program.[3]
- Seven carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Missouri is a

Low-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Missouri is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Missouri has not expanded Medicaid, which would provide coverage for an estimated 283,000 people in the state.[5]

For continutity-of-care metrics, relative to other states, Missouri is a

Low-Performing State

## A MORE PATIENT-FOCUSED MISSOURI MARKETPLACE

Missouri has not exercised its full authority to regulate the exchange to promote patient protections. Missouri's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Missouri would have more control over exchange plans if the state opted to create a state-based exchange or, as an intermediary step, a partnership or exchange plan management model. Missouri has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Missouri also could become an active purchaser, which could help the state better manage increasing premiums. Another critical step towards a patient-friendly health insurance market would be for Missouri to expand Medicaid. Expansion of Medicaid would provide health insurance for more than 283,000 Missourians.

## METHODOLOGY

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For definitions of key terms, see the National Health Council's Putting Patients First® glossary.

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4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

5 Kaiser Family Foundation, "A Closer Look at the Impact of State Decisions Not to Expand Medicaid Coverage for Uninsured Adults," April 24, 2014, accessed via: http://kff.org/medicaid/fact-sheet/a-closer-look-at-the-impact-of-state-decisions-not-to-expand-medicaid-on-coverage-for-uninsured-adults/

# Montana Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- ● Montana requires that health insurance companies cover all prescription drugs equally at a flat dollar copay for all plans with an actuarial value equal to, or greater than 70%.
- ◐ Two unique platinum offerings in the 2015 exchange.
- ● Montana has implemented increased network adequacy standards for health plans. Plans are required to include at least 80% of all Essential Community Providers—a standard that exceeds the federal requirement of 30%.
- ● The premium for the 2nd lowest cost silver plan is 7% lower in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Montana is a

High-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- ◐ HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- ◐ No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Montana is a

Low-Performing State

### MONTANA HIGHLIGHTS

Montana's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 36,600 Montanans selected an exchange plan through HealthCare.gov. About 30% of Montana residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Montana has not expanded Medicaid.

### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- ● Beneficial for Patients
- ◐ Neutral for Patients
- ● Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.

- High-Performing
- Average-Performing
- Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Five carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Montana is an

Average-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Montana is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Montana has not expanded Medicaid, which would provide coverage for an estimated 63,000 people in the state.[5]

For continutity-of-care metrics, relative to other states, Montana is a

Low-Performing State

## A MORE PATIENT-FOCUSED MONTANA MARKETPLACE

While Montana has taken steps to limit discrimination, it has not exercised its full authority to regulate the exchange to promote patient protections. Montana's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Montana would have more control over exchange plans if the state opted to create a state-based exchange. Montana has yet to establish standards that would increase transparency or uniformity, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Montana also could become an active purchaser. Another critical step towards a patient-friendly health insurance market would be for Montana to expand Medicaid. Expansion of Medicaid would provide health insurance for more than 63,000 Montanans.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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# Nebraska Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- One unique platinum plan offering in the 2015 exchange.
- Nebraska enacted legislation requiring managed care issuers to maintain a network that is sufficient in numbers and types of providers to ensure that enrollees have access to healthcare services without unreasonable delay.
- The premium for the 2nd lowest cost silver plan is 3% lower in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Nebraska is an

Average-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Nebraska is a

Low-Performing State

### NEBRASKA HIGHLIGHTS

Nebraska's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 43,000 Nebraskans selected an exchange plan through HealthCare.gov. About 18% of Nebraska residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Nebraska has not expanded Medicaid.

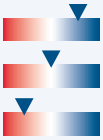
### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing
Average-Performing
Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Four carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Nebraska is an

Average-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Nebraska is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Nebraska has not expanded Medicaid, which would provide coverage for an estimated 56,000 people in the state.[5]

For continuity-of-care metrics, relative to other states, Nebraska is a

Low-Performing State

## A MORE PATIENT-FOCUSED NEBRASKA MARKETPLACE

Nebraska has not exercised its full authority to regulate the exchange to promote patient protections. Nebraska's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Nebraska would have more control over exchange plans if the state opted to create a state-based exchange. Nebraska has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Further, the state has very few platinum plans, which limits options for the people who would benefit most—those with chronic conditions and disabilities. Contracting requirements could encourage, or potentially require, carriers to offer a platinum plan.

Another critical step towards a patient-friendly health insurance market would be for Nebraska to expand Medicaid. Expansion of Medicaid would provide health insurance for more than 56,000 Nebraskans.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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5 Kaiser Family Foundation, "A Closer Look at the Impact of State Decisions Not to Expand Medicaid Coverage for Uninsured Adults," April 24, 2014, accessed via: http://kff.org/medicaid/fact-sheet/a-closer-look-at-the-impact-of-state-decisions-not-to-expand-medicaid-on-coverage-for-uninsured-adults/

# Nevada Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- ◐ No state action to limit discrimination.
- ◐ Nine unique platinum offerings in the 2015 exchange.
- ◐ No state action on provider network requirements.
- ● The premium for the 2nd lowest cost silver plan is less than 1% lower in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Nevada is an

Average-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- ◐ HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- ◐ No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Nevada is a

Low-Performing State

### NEVADA HIGHLIGHTS

Nevada is a supported state-based exchange. Although the state created its own exchange, called Nevada Health Link, it is enrolling individuals through the federal enrollment portal, HealthCare.gov.

In the 2014 plan year, 43,000 Nevadans selected an exchange plan through Nevada Health Link. About 17% of Nevada residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Nevada expanded Medicaid, effective in 2014.

### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- ● Beneficial for Patients
- ◐ Neutral for Patients
- ● Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.

High-Performing
Average-Performing
Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Active purchasing—the state actively negotiates with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Seven carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Nevada is an

Average-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Nevada is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Nevada expanded Medicaid, which now covers an estimated 216,000 people in the state.

For continuity-of-care metrics, relative to other states, Nevada is an

Average-Performing State

## A MORE PATIENT-FOCUSED NEVADA MARKETPLACE

Nevada has not exercised its full authority to regulate the exchange to promote patient protections. Although Nevada is a state-based exchange, its reliance on HealthCare.gov for enrollment reduces its ability to influence shopping tools available to customers. Nevada would have more control over exchange plans if the state operated its own enrollment platform. Additionally, through legislative or other state action, Nevada could standardize benefit designs or plan benefit materials. The state also could consider oversight activities that would screen exchange plans for discrimination, and promote continuity-of-care requirements to ensure that patients with chronic conditions have access to care.

## METHODOLOGY

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# New Hampshire Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- One unique platinum offering in the 2015 exchange.
- New Hampshire enacted legislation requiring issuers to maintain a network that is sufficient in numbers, types, and geographic location of providers to ensure adequate access to healthcare services without unreasonable delay.
- The premium for the 2nd lowest cost silver plan is 15% lower in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, New Hampshire is an

Average-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, New Hampshire is a

Low-Performing State

### NEW HAMPSHIRE HIGHLIGHTS

New Hampshire established a state-federal partnership exchange. The state is responsible for managing plan participation and customer assistance in the exchange. New Hampshire residents use the federal exchange, HealthCare.gov, to compare and purchase coverage.

In the 2014 plan year, 40,300 New Hampshirites selected an exchange plan through HealthCare.gov. About 39% of New Hampshire residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

New Hampshire expanded Medicaid, effective in 2014.

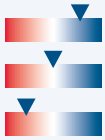
### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing

Average-Performing

Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Six carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, New Hampshire is an

Average-Performing State

## UNIFORMITY

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, New Hampshire is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- New Hampshire expanded Medicaid under a premium assistance model, which now covers an estimated 40,000 people.

For continuity-of-care metrics, relative to other states, New Hampshire is an

Average-Performing State

## A MORE PATIENT-FOCUSED NEW HAMPSHIRE MARKETPLACE

New Hampshire's partial reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. New Hampshire would have more control over exchange plans if the state opted to create a state-based exchange. New Hampshire has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Further, the state has very few platinum plans, which limits options for the people who would benefit most—those with chronic conditions and disabilities. Contracting requirements could encourage, or potentially require, carriers to offer a platinum plan.

As New Hampshire implements the premium assistance model, the state should ensure the model preserves patient protections inherent in Medicaid.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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# New Jersey Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have taken extra steps to make their markets more patient-focused. This Progress Report measures a state across five principles to assess how well its insurance market is designed to meet the needs of people with chronic diseases and disabilities.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- ◐ No state action to limit discrimination.
- ◐ Six unique platinum offerings in the 2015 exchange.
- ◐ No state action on provider network requirements.
- ● The premium for the 2nd lowest cost silver plan is 2% lower in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, New Jersey is an

Average-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- ◐ HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- ◐ No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, New Jersey is a

Low-Performing State

### NEW JERSEY HIGHLIGHTS

New Jersey's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 161,800 New Jerseyans selected an exchange plan through HealthCare.gov. About 27% of New Jersey residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

New Jersey expanded Medicaid, effective January 1, 2014.

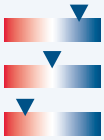
### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- ● Beneficial for Patients
- ◐ Neutral for Patients
- ● Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing

Average-Performing

Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Five carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, New Jersey is an

Average-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, New Jersey is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- New Jersey expanded Medicaid, which now covers an estimated 374,000 people in the state.

For continuity-of-care metrics, relative to other states, New Jersey is an

Average-Performing State

## A MORE PATIENT-FOCUSED NEW JERSEY MARKETPLACE

New Jersey has not exercised its full authority to regulate the exchange to promote patient protections. New Jersey's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. New Jersey would have more control over exchange plans if the state opted to create a state-based exchange or, as an intermediary step, a partnership or exchange plan management model. New Jersey has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, New Jersey also could become an active purchaser.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

For definitions of key terms, see the National Health Council's Putting Patients First® glossary.

1 Kaiser Family Foundation, "Estimated Number of Individuals Eligible for Financial Assistance through the Marketplaces," November, 2014, accessed via: http://kff.org/other/state-indicator/estimated-number-of-individuals-eligible-for-premium-tax-credits-through-the-marketplaces/

2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

# New Mexico Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- One unique platinum offering in the 2015 exchange.
- No state action on provider network requirements.
- The premium for the 2nd lowest cost silver plan is 12% lower in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, New Mexico is an

Average-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, New Mexico is a

Low-Performing State

### NEW MEXICO HIGHLIGHTS

New Mexico is a supported state-based exchange. Although the state created its own exchange, called beWellnm, it is enrolling individuals through the federal enrollment portal, HealthCare.gov.

In the 2014 plan year, 32,100 New Mexicans selected an exchange plan through HealthCare.gov. About 21% of New Mexico residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

New Mexico expanded Medicaid, effective in 2014.

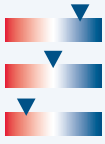
### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing
Average-Performing
Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- New Mexico limited 2015 exchange participation to only those issuers that joined in 2014. New issuers may offer coverage through the exchange starting in 2016.
- Its effective rate review program allows the state to manage premium increases.[3]
- Seven carriers in the 2015 exchange market.

For state-oversight metrics, relative to other states, New Mexico is an

Average-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, New Mexico is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- New Mexico expanded Medicaid, which now covers an estimated 184,000 people in the state.

For continuity-of-care metrics, relative to other states, New Mexico is an

Average-Performing State

## A MORE PATIENT-FOCUSED NEW MEXICO MARKETPLACE

New Mexico has not exercised its full authority to regulate the exchange to promote patient protections. Although New Mexico is a state-based exchange, its reliance on HealthCare.gov for enrollment reduces its ability to influence shopping tools available to customers. New Mexico would have more control over exchange plans if the state operated its own enrollment platform; however, its recent decision to halt development of its own exchange enrollment website limits opportunities to increase health plan transparency and improve uniformity of content. As a state-based exchange, New Mexico could become an active purchaser, take further action to protect patients from discrimination, and develop continuity-of-care requirements to help patients maintain access to care. Further, the state has very few platinum plans, which limits options for the people who would benefit most—those with chronic conditions and disabilities. Contracting requirements could encourage, or potentially require, carriers to offer a platinum plan.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

# New York Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have taken extra steps to make their markets more patient-focused. This Progress Report measures a state across five principles to assess how well its insurance market is designed to meet the needs of people with chronic diseases and disabilities.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- New York was the first state to enact legislation to limit specialty tiers. The law prohibits plans from charging cost-sharing amounts that exceed amounts for non-preferred brand or the equivalent.
- Thirty-nine unique platinum offerings in the 2015 exchange.
- New York required plans to allow in-network cost sharing for out-of-network providers when an appropriate provider is not available within the plan's network. Additionally, network directories must be updated within 15 days of providers joining or leaving a plan's network.
- The premium for the 2nd lowest cost silver plan is 2% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, New York is a

High-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- New York's website links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks formulary and provider search tools and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, New York is a

Low-Performing State

### NEW YORK HIGHLIGHTS

New York established a state-based exchange, called New York State of Health.

In the 2014 plan year, 370,600 New Yorkers selected an exchange plan through New York State of Health. About 30% of New York residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

New York expanded Medicaid, effective January 1, 2014.

### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.

High-Performing

Average-Performing

Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Active purchasing—the state actively negotiates with plans to participate in the exchange.
- New York requires multi-year contracts, limits the number of bids submitted by issuers, ties participation outside and inside the exchange, and requires plans to offer products in specific metals levels, including catastrophic plans.
- Its effective rate review program allows the state to manage premium increases.[3]
- Seventeen carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, New York is a

High-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- New York standardized benefit designs.
- New York rates exhange plans using a four-star quality rating system. By 2016, New York intends to develop a five-star quality star rating system, which contains the following five domains for each product: consumer satisfaction, children's health, pregnancy care, adult health, and health conditions.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, New York is a

High-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- New York requires issuers new to the exchange in 2015 to also participate in Medicaid managed care. New York also provided additional premium subsidies beyond the federal requirement for individuals between 138 and 150 percent of the federal poverty level.
- New York expanded Medicaid, which now covers an estimated 518,000 people in the state.

For continuity-of-care metrics, relative to other states, New York is a

High-Performing State

## A MORE PATIENT-FOCUSED NEW YORK MARKETPLACE

New York has achieved considerable success in fostering a patient-focused market, as they have taken numerous state actions, beyond the federal requirements, that better protect patients.

However, New York has not exercised its full authority to regulate the exchange to promote patient protections. Notably, the state could enact contracting requirements to enhance plan information transparency, and standardize display of plan information. Patients would also benefit from the development of an out-of-pocket calculator to estimate health expenses and better inform plan selection.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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# North Carolina Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have taken extra steps to make their markets more patient-focused. This Progress Report measures a state across five principles to assess how well its insurance market is designed to meet the needs of people with chronic diseases and disabilities.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- ◐ No state action to limit discrimination.
- ◐ Four unique platinum offerings in the 2015 exchange.
- ◐ No state actions on network requirements.
- ● The premium for the 2nd lowest cost silver plan is 7% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, North Carolina is a

Low-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- ◐ HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- ◐ No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, North Carolina is a

Low-Performing State

### NORTH CAROLINA HIGHLIGHTS

North Carolina's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 357,600 North Carolinians selected an exchange plan through HealthCare.gov. About 33% of North Carolina residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

North Carolina has not expanded Medicaid.

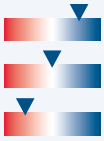
### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- ● Beneficial for Patients
- ◐ Neutral for Patients
- ● Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing

Average-Performing

Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Four carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, North Carolina is an

Average-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, North Carolina is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- North Carolina has not expanded Medicaid, which would provide coverage for an estimated 511,000.[5]

For continuity-of-care metrics, relative to other states, North Carolina is a

Low-Performing State

## A MORE PATIENT-FOCUSED NORTH CAROLINA MARKETPLACE

North Carolina has not exercised its full authority to regulate the exchange to promote patient protections. North Carolina's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. North Carolina would have more control over exchange plans if the state opted to create a state-based exchange or, as an intermediary step, a partnership or exchange plan management model. North Carolina has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, North Carolina also could become an active purchaser. Another critical step towards a patient-friendly health insurance market would be for North Carolina to expand Medicaid. Expansion of Medicaid would provide health insurance for over 500,000 North Carolinians.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

5 Kaiser Family Foundation, "A Closer Look at the Impact of State Decisions Not to Expand Medicaid Coverage for Uninsured Adults," April 24, 2014, accessed via: http://kff.org/medicaid/fact-sheet/a-closer-look-at-the-impact-of-state-decisions-not-to-expand-medicaid-on-coverage-for-uninsured-adults/

# North Dakota Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- North Dakota has no platinum offerings in the 2015 exchange.
- No state action on provider network requirements.
- The premium for the 2nd lowest cost silver plan is less than 1% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, North Dakota is an

Average-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, North Dakota is a

Low-Performing State

### NORTH DAKOTA HIGHLIGHTS

North Dakota's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 10,600 North Dakotans selected an exchange plan through HealthCare.gov. About 13% of North Dakota residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

North Dakota expanded Medicaid, effective January 1, 2014.

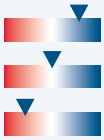
### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing

Average-Performing

Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Three carriers in the 2015 exchange market.

For state-oversight metrics, relative to other states, North Dakota is an

Average-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, North Dakota is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- North Dakota expanded Medicaid, which now covers an estimated 12,000 people in the state.

For continutity-of-care metrics, relative to other states, North Dakota is an

Average-Performing State

## A MORE PATIENT-FOCUSED NORTH DAKOTA MARKETPLACE

North Dakota has not exercised its full authority to regulate the exchange to promote patient protections. North Dakota's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. North Dakota would have more control over exchange plans if the state opted to create a state-based exchange or, as an intermediary step, a partnership or exchange plan management model. North Dakota has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. In addition, North Dakota's exchange does not foster competition as there are only three carriers offering coverage. As a result, there are no platinum plans offered in the state, limiting options for people who would benefit most—those with chronic conditions and disabilities. Under a different operational model, North Dakota also could become an active purchaser.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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# Ohio Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have taken extra steps to make their markets more patient-focused. This Progress Report measures a state across five principles to assess how well its insurance market is designed to meet the needs of people with chronic diseases and disabilities.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- ◐ No state action to limit discrimination.
- ◐ Four unique platinum offerings in the 2015 exchange.
- ◐ No state action on provider network requirements.
- ● The premium for the 2nd lowest cost silver plan is 1% lower in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Ohio is an

Average-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- ◐ HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- ◐ No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Ohio is a

Low-Performing State

### OHIO HIGHLIGHTS

Ohio's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 154,700 Ohioans selected an exchange plan through HealthCare.gov. About 17% of Ohio residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Ohio expanded Medicaid, effective January 1, 2014.

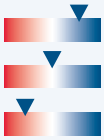
### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- ● Beneficial for Patients
- ◐ Neutral for Patients
- ● Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing

Average-Performing

Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Sixteen carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Ohio is an

Average-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Ohio is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Ohio expanded Medicaid, which now covers an estimated 526,000 people in the state.

For continuity-of-care metrics, relative to other states, Ohio is an

Average-Performing State

## A MORE PATIENT-FOCUSED OHIO MARKETPLACE

Ohio has not exercised its full authority to regulate the exchange to promote patient protections. Ohio's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Ohio would have more control over exchange plans if the state opted to create a state-based exchange. Ohio has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Ohio also could become an active purchaser. The state has few platinum plans, which limits options for the people who would benefit the most—those with chronic conditions and disabilities.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

For definitions of key terms, see the National Health Council's Putting Patients First® glossary.

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3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

# Oklahoma Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- ◐ No state action to limit discrimination.
- ● One unique platinum offering in the 2015 exchange.
- ◐ No state action on provider network requirements.
- ● The premium for the 2nd lowest cost silver plan is 9% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Oklahoma is a


Low-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- ◐ HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- ◐ No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Oklahoma is a


Low-Performing State

### OKLAHOMA HIGHLIGHTS

Oklahoma's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 69,200 Oklahomans selected an exchange plan through HealthCare.gov. About 17% of Oklahoma residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Oklahoma has not expanded Medicaid.

### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- ● Beneficial for Patients
- ◐ Neutral for Patients
- ● Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.


High-Performing


Average-Performing


Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Oklahoma does not have an effective rate review.[3]
- Five carriers in the 2015 exchange market.

For state-oversight metrics, relative to other states, Oklahoma is a

Low-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Oklahoma is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Oklahoma has not expanded Medicaid, which would provide coverage for an estimated 201,000 people in the state.[5]

For continutity-of-care metrics, relative to other states, Oklahoma is a

Low-Performing State

## A MORE PATIENT-FOCUSED OKLAHOMA MARKETPLACE

Oklahoma has not exercised its full authority to regulate the exchange to promote patient protections. Oklahoma's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Oklahoma would have more control over exchange plans if the state opted to create a state-based exchange or, as an intermediary step, a partnership or exchange plan management model. Oklahoma has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Oklahoma also could become an active purchaser, which could help the state better manage increasing premiums. In addition, the state has very few platinum plans, which limits options for the people who would benefit most—those with chronic conditions and disabilities. Another critical step towards a patient-friendly health insurance market would be for Oklahoma to expand Medicaid. Expansion of Medicaid would provide health insurance for more than 201,000 Oklahomans.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

5 Kaiser Family Foundation, "A Closer Look at the Impact of State Decisions Not to Expand Medicaid Coverage for Uninsured Adults," April 24, 2014, accessed via: http://kff.org/medicaid/fact-sheet/a-closer-look-at-the-impact-of-state-decisions-not-to-expand-medicaid-on-coverage-for-uninsured-adults/

# Oregon Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- ◐ No state action to limit discrimination.
- ◐ Two unique platinum offerings in the 2015 exchange.
- ◐ No state action on provider network requirements.
- ● The premium for the 2nd lowest cost silver plan is 6% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Oregon is a

Low-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- ◐ HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- ◐ No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Oregon is a

Low-Performing State

### OREGON HIGHLIGHTS

Oregon is a supported state-based exchange. Although the state created its own exchange, called Cover Oregon, it is enrolling individuals through the federal enrollment portal, HealthCare.gov.

In the 2014 plan year, 77,300 Oregonians selected an exchange plan through HealthCare.gov. About 24% of Oregon residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Oregon expanded Medicaid, effective in 2014.

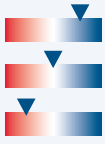
### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- ● Beneficial for Patients
- ◐ Neutral for Patients
- ● Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing

Average-Performing

Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Active purchasing—the state actively negotiates with plans to participate in the exchange.
- Oregon requires multi-year contracts and limits the number of bids submitted by issuers.
- Its effective rate review program allows the state to manage premium increases.[3]
- Eleven carriers in the 2015 exchange market.

For state-oversight metrics, relative to other states, Oregon is a

High-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- Oregon standardized benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Oregon is a

High-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Oregon expanded Medicaid, which now covers an estimated 405,000 people in the state.

For continuity-of-care metrics, relative to other states, Oregon is an

Average-Performing State

## A MORE PATIENT-FOCUSED OREGON MARKETPLACE

Oregon has not exercised its full authority to regulate the exchange to promote patient protections. Although Oregon is a state-based exchange, its reliance on HealthCare.gov for enrollment reduces its ability to influence shopping tools available to customers. Oregon would have more control over exchange plans if the state operated its own enrollment platform. The state also could consider oversight activities that would screen exchange plans for discrimination, and bolster requirements for plan information transparency. Further, the state has very few platinum plans, which limits options for the people who would benefit most—those with chronic conditions and disabilities. Contracting requirements could encourage, or potentially require, carriers to offer a platinum plan.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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# Pennsylvania Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have taken extra steps to make their markets more patient-focused. This Progress Report measures a state across five principles to assess how well its insurance market is designed to meet the needs of people with chronic diseases and disabilities.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- ◐ No state action to limit discrimination.
- ● Twenty unique platinum offerings in the 2015 exchange.
- ◐ No state action on provider network requirements.
- ● The premium for the 2nd lowest cost silver plan is 11% lower in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Pennsylvania is an

Average-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- ◐ HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- ◐ No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Pennsylvania is a

Low-Performing State

### PENNSYLVANIA HIGHLIGHTS

Pennsylvania's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 318,100 Pennsylvanians selected an exchange plan through HealthCare.gov. About 35% of Pennsylvania residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Pennsylvania expanded Medicaid, effective January 1, 2015.

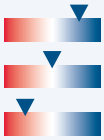
### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- ● Beneficial for Patients
- ◐ Neutral for Patients
- ● Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing

Average-Performing

Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Eleven carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Pennsylvania is an

Average-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Pennsylvania is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Pennsylvania expanded Medicaid, which now covers an estimated 2,000 people.

For continuity-of-care metrics, relative to other states, Pennsylvania is an

Average-Performing State

## A MORE PATIENT-FOCUSED PENNSYLVANIA MARKETPLACE

Pennsylvania has not exercised its full authority to regulate the exchange to promote patient protections. Pennsylvania's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Pennsylvania would have more control over exchange plans if the state opted to create a state-based exchange or, as an intermediary step, a partnership or exchange plan management model. Pennsylvania has yet to establish exchange standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Pennsylvania also could become an active purchaser.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

# Rhode Island Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- No unique platinum offerings in the 2015 exchange.
- No state action on provider network requirements.
- The premium for the 2nd lowest cost silver plan is 11% lower in 2015, than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Rhode Island is an

Average-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- Rhode Island's website allows consumers to filter plan options and has links to plans' provider directories and formularies. The website also features a provider search tool, and a calculator to help estimate tax credit amounts. However, the website lacks a formulary search tool.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Rhode Island is an

Average-Performing State

### RHODE ISLAND HIGHLIGHTS

Rhode Island established a state-based exchange, called HealthSource RI.

In the 2014 plan year, 28,500 Rhode Islanders selected an exchange plan through HealthSource RI. About 39% of Rhode Island residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Rhode Island expanded Medicaid, effective in 2014.

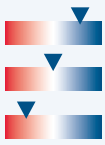
### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



- High-Performing
- Average-Performing
- Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Active purchasing—the state actively negotiates with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange.
- Its effective rate review program allows the state to manage premium increases.[3]
- Three carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Rhode Island is an

Average-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- Rhode Island is developing quality rating measures for use in future plan years.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Rhode Island is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.
- Rhode Island expanded Medicaid, which now covers an estimated 73,000 people.[4]

For continuity-of-care metrics, relative to other states, Rhode Island is an

Average-Performing State

## A MORE PATIENT-FOCUSED RHODE ISLAND MARKETPLACE

Rhode Island has achieved some success in fostering a patient-focused market, as they have taken several state actions, beyond the federal requirements, that better protect patients.

However, Rhode Island has not exercised its full authority to regulate the exchange to promote patient protections. Through legislative or other state action, Rhode Island could standardize benefit designs or plan benefit materials. The state also could consider oversight activities to screen exchange plans for discrimination, and enhance network adequacy requirements. Patients would benefit from the development of quality rating measures to better inform plan selection. Further, the state has very few platinum plans, which limits options for the people who would benefit most—those with chronic conditions and disabilities. Contracting requirements could encourage, or potentially require, carriers to offer a platinum plan.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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# South Carolina Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- One unique platinum offering in the 2015 exchange.
- No state action on provider network requirements.
- The premium for the 2nd lowest cost silver plan is 3% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, South Carolina is a

Low-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, South Carolina is a

Low-Performing State

### SOUTH CAROLINA HIGHLIGHTS

South Carolina's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 118,300 South Carolinians selected an exchange plan through HealthCare.gov. About 27% of South Carolina residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

South Carolina has not expanded Medicaid.

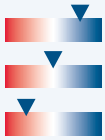
### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing

Average-Performing

Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Seven carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, South Carolina is an

Average-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, South Carolina is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- South Carolina has not expanded Medicaid, which would provide coverage for an estimated 289,000 people in the state.[5]

For continuity-of-care metrics, relative to other states, South Carolina is a

Low-Performing State

## A MORE PATIENT-FOCUSED SOUTH CAROLINA MARKETPLACE

South Carolina has not exercised its full authority to regulate the exchange to promote patient protections. South Carolina's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. South Carolina would have more control over exchange plans if the state opted to create a state-based exchange or, as an intermediary step, a partnership or exchange plan management model. South Carolina has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, South Carolina also could become an active purchaser, which could help the state better manage increasing premiums. Further, the state has only a single platinum plan, which limits options for the people who would benefit most—those with chronic conditions and disabilities. Contracting requirements could encourage, or potentially require, carriers to offer a platinum plan.

Another critical step towards a patient-friendly health insurance market would be for South Carolina to expand Medicaid. Expansion of Medicaid would provide health insurance for more than 289,000 South Carolina residents.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

5 Kaiser Family Foundation, "A Closer Look at the Impact of State Decisions Not to Expand Medicaid Coverage for Uninsured Adults," April 24, 2014, accessed via: http://kff.org/medicaid/fact-sheet/a-closer-look-at-the-impact-of-state-decisions-not-to-expand-medicaid-on-coverage-for-uninsured-adults/

# South Dakota Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- One unique platinum offering in the 2015 exchange.
- South Dakota requires issuers to include any willing and qualified provider in plan networks.
- The premium for the 2nd lowest cost silver plan is 3% lower in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, South Dakota is an

Average-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, South Dakota is a

Low-Performing State

### SOUTH DAKOTA HIGHLIGHTS

South Dakota's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 13,100 South Dakotans selected an exchange plan through HealthCare.gov. About 13% of South Dakota residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

South Dakota has not expanded Medicaid.

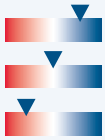
### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



- High-Performing
- Average-Performing
- Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Three carriers in the 2015 exchange market.

For state-oversight metrics, relative to other states, South Dakota is an

Average-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, South Dakota is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- South Dakota has not expanded Medicaid, which would provide coverage for an estimated 40,000 people in the state.[5]

For continuity-of-care metrics, relative to other states, South Dakota is a

Low-Performing State

## A MORE PATIENT-FOCUSED SOUTH DAKOTA MARKETPLACE

South Dakota has not exercised its full authority to regulate the exchange to promote patient protections. South Dakota's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. South Dakota would have more control over exchange plans if the state opted to create a state-based exchange. South Dakota has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Further, the state has very few platinum plans, which limits options for the people who would benefit most—those with chronic conditions and disabilities. Contracting requirements could encourage, or potentially require, carriers to offer a platinum plan.

Another critical step towards a patient-friendly health insurance market would be for South Dakota to expand Medicaid. Expansion of Medicaid would provide health insurance for more than 40,000 South Dakotans.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

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4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

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# Tennessee Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- Ten unique platinum offerings in the 2015 exchange.
- Tennessee enacted legislation requiring each managed care issuer to maintain a network that is sufficient in numbers and types of providers in order to ensure access without unreasonable delay.
- The premium for the 2nd lowest cost silver plan is 8% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Tennessee is an

Average-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Tennessee is a

Low-Performing State

### TENNESSEE HIGHLIGHTS

Tennessee's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 151,400 Tennesseeans selected an exchange plan through HealthCare.gov. About 26% of Tennessee residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Tennessee has not expanded Medicaid.

### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.

High-Performing

Average-Performing

Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Seven carriers in the 2015 exchange market.

For state-oversight metrics, relative to other states, Tennessee is an

Average-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Tennessee is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Tennessee has not expanded Medicaid, which would provide coverage for an estimated 266,000 people in the state.[5]

For continutity-of-care metrics, relative to other states, Tennessee is a

Low-Performing State

## A MORE PATIENT-FOCUSED TENNESSEE MARKETPLACE

Tennessee has not exercised its full authority to regulate the exchange to promote patient protections. Tennessee's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Tennessee would have more control over exchange plans if the state opted to create a state-based exchange or, as an intermediary step, a partnership or exchange plan management model. Tennessee has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Tennessee also could become an active purchaser, which could help the state better manage increasing premiums. Another critical step towards a patient-friendly health insurance market would be for Tennessee to expand Medicaid. Expansion of Medicaid would provide health insurance for more than 266,000 Tennesseeans.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

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# Texas Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have taken extra steps to make their markets more patient-focused. This Progress Report measures a state across five principles to assess how well its insurance market is designed to meet the needs of people with chronic diseases and disabilities.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- Eleven unique platinum offerings in the 2015 exchange.
- Texas enacted legislation requiring the insurance commissioner to adopt network adequacy standards that ensure access to "a full range" of physician providers.
- The premium for the 2nd lowest cost silver plan is 5% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Texas is an

Average-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Texas is a

Low-Performing State

### TEXAS HIGHLIGHTS

Texas' exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 733,800 Texans selected an exchange plan through HealthCare.gov. About 24% of Texas residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Texas has not expanded Medicaid.

### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.

- High-Performing
- Average-Performing
- Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Texas does not have an effective rate review program.[3]
- Fourteen carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Texas is an

Average-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Texas is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Texas has not expanded Medicaid, which would provide coverage for an estimated 1,727,000 people in the state.[5]

For continuity-of-care metrics, relative to other states, Texas is a

Low-Performing State

## A MORE PATIENT-FOCUSED TEXAS MARKETPLACE

Texas has not exercised its full authority to regulate the exchange to promote patient protections. Texas' reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Texas would have more control over exchange plans if the state opted to create a state-based exchange or, as an intermediary step, a partnership or exchange plan management model. Texas has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Texas also could become an active purchaser. Another critical step towards a patient-friendly health insurance market would be for Texas to expand Medicaid. Expansion of Medicaid would provide health insurance for more than 1.7 million Texans.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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# Utah Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- One unique platinum offering in the 2015 exchange.
- No state action on provider network requirements.
- The premium for the 2nd lowest cost silver plan is 3% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Utah is a

Low-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Utah is a

Low-Performing State

### UTAH HIGHLIGHTS

Utah's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 84,600 Utahans selected an exchange plan through HealthCare.gov. About 23% of Utah residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Utah has not expanded Medicaid.

### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.

- High-Performing
- Average-Performing
- Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Seven carriers in the 2015 exchange market.

For state-oversight metrics, relative to other states, Utah is an

Average-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Utah is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Utah has not expanded Medicaid, which would provide coverage for an estimated 93,000 people in the state.[5]

For continuity-of-care metrics, relative to other states, Utah is a

Low-Performing State

## A MORE PATIENT-FOCUSED UTAH MARKETPLACE

Utah has not exercised its full authority to regulate the exchange to promote patient protections. Utah's reliance on the federal government to run the exchange reduces the state's influence over its own individual health insurance market. Utah would have more control over exchange plans if the state opted to create a state-based exchange. Utah has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Utah also could become an active purchaser, which could help the state better manage increasing premiums. Further, the state has only a single platinum plan, which limits options for the people who would benefit most—those with chronic conditions and disabilities. Contracting requirements could encourage, or potentially require, carriers to offer a platinum plan.

Another critical step towards a patient-friendly health insurance market would be for Utah to expand Medicaid. Expansion of Medicaid would provide health insurance for more than 93,000 Utahans.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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# Vermont Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- ◐ No state action to limit discrimination.
- ◐ Two unique platinum offerings in the 2015 exchange.
- ● Vermont enacted legislation requiring exchange plans to meet specified minimum network adequacy standards.
- ● The premium for the 2nd lowest cost silver plan is 6% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Vermont is an

Average-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- ● Vermont's website has links to plans' provider directories and formularies as well as a calculator to estimate projected subsidy amounts. However, because of required sensitive information to browse plans, NHC was unable to fully examine the exchange enrollment portal; therefore, it is unclear if the website has formulary and provider search tools or allows consumers to filter plan options.
- ◐ No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Vermont is an

Average-Performing State

### VERMONT HIGHLIGHTS

Vermont established a state-based exchange, called Vermont Health Connect.

In the 2014 plan year, 31,500 Vermont residents selected an exchange plan through Vermont Health Connect. About 70% of Vermont residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Vermont expanded Medicaid, effective January 1, 2014.

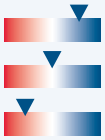
### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- ● Beneficial for Patients
- ◐ Neutral for Patients
- ● Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



- High-Performing
- Average-Performing
- Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Active purchasing – the state actively negotiates with plans to participate in the exchange.
- Vermont ties participation outside and inside the exchange and requires plans by a single issuer to have distinct differences.
- Its effective rate review program allows the state to manage premium increases.[3]
- Two carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Vermont is a

High-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- Vermont standardized benefit designs.
- Vermont does not have a quality rating system in place for the 2015 plan year, and has not released materials to date on the development of a quality rating system for the 2016 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Vermont is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- Vermont reduces premiums and cost sharing, beyond federally funded subsidies, for qualifying exchange enrollees.
- Vermont expanded Medicaid, which now covers an estimated 87,000 people in the state.

For continutity-of-care metrics, relative to other states, Vermont is a

High-Performing State

## A MORE PATIENT-FOCUSED VERMONT MARKETPLACE

Vermont has achieved some success in fostering a patient-focused market, as they have taken several state actions, beyond the federal requirements, that better protect patients.

However, Vermont has not exercised its full authority to regulate the exchange to promote patient protections. The state could improve its transparency by allowing the general public to view exchange plan offerings without creating an account. For those able to view exchange offerings, Vermont may pass legislation requiring greater clarity on plan benefits and develop quality rating measures to better inform patients' plan selection. In addition, Vermont's exchange does not foster competition as there are only two carriers offering coverage. As a result of the lack of competition, there are few platinum plans offered in the state, limiting options for the people who would benefit most—those with chronic conditions and disabilities.

## METHODOLOGY

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1 Kaiser Family Foundation, "Estimated Number of Individuals Eligible for Financial Assistance through the Marketplaces," November, 2014, accessed via: http://kff.org/other/state-indicator/estimated-number-of-individuals-eligible-for-premium-tax-credits-through-the-marketplaces/

2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

# Virginia Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- Two unique platinum offerings in the 2015 exchange.
- No state action on provider network requirements.
- The premium for the 2nd lowest cost silver plan is 3% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Virginia is an

Average-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Virginia is a

Low-Performing State

### VIRGINIA HIGHLIGHTS

Virginia's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 216,400 Virginians selected an exchange plan through HealthCare.gov. About 26% of Virginia residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Virginia has not expanded Medicaid.

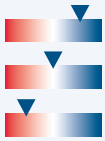
### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



- High-Performing
- Average-Performing
- Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Nine carriers in the 2015 exchange market.

For state-oversight metrics, relative to other states, Virginia is an

Average-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Virginia is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- Virginia enacted legislation requiring issuers to notify enrollees at least 30 days before certain mid-year changes to formularies that would result in higher out-of-pocket costs.
- Virginia has not expanded Medicaid, which would provide coverage for an estimated 314,000 people in the state.[5]

For continuity-of-care metrics, relative to other states, Virginia is an

Average-Performing State

## A MORE PATIENT-FOCUSED VIRGINIA MARKETPLACE

Virginia has not exercised its full authority to regulate the exchange to promote patient protections. Virginia's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Virginia would have more control over exchange plans if the state opted to create a state-based exchange. Virginia has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Virginia also could become an active purchaser, which could help the state better manage increasing premiums. Further, the state has very few platinum plans, which limits options for the people who would benefit most—those with chronic conditions and disabilities. Contracting requirements could encourage, or potentially require, carriers to offer a platinum plan.

Another critical step towards a patient-friendly health insurance market would be for Virginia to expand Medicaid. Expansion of Medicaid would provide health insurance for more than 314,000 Virginians.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

5 Kaiser Family Foundation, "A Closer Look at the Impact of State Decisions Not to Expand Medicaid Coverage for Uninsured Adults," April 24, 2014, accessed via: http://kff.org/medicaid/fact-sheet/a-closer-look-at-the-impact-of-state-decisions-not-to-expand-medicaid-on-coverage-for-uninsured-adults/

# Washington Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have taken extra steps to make their markets more patient-focused. This Progress Report measures a state across five principles to assess how well its insurance market is designed to meet the needs of people with chronic diseases and disabilities.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- Washington has issued regulations that limit discrimination in exchange plans by setting increased standards for coverage and grants the insurance commissioner broad authority to reject plans with discriminatory benefits.
- Five unique platinum plans in the 2015 exchange.
- Washington requires minimum standards for provider networks, such as having access to urgent care within a set timeframe. The state also requires that in-network costs apply to out-of-network providers in certain conditions.[2]
- The premium for the 2nd lowest cost silver plan is 10% lower in 2015 than it was in 2014.[3]

For non-discrimination metrics, relative to other states, Washington is a

High-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- Washington's exchange website has a provider search tool and the ability to filter search results. The website lacks a formulary search tool, access to plans' formularies and provider networks, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Washington is an

Average-Performing State

### WASHINGTON HIGHLIGHTS

Washington established a state-based exchange, called Washington Healthplanfinder.

In the 2014 plan year, 147,900 Washingtonians selected an exchange plan through Washington Healthplanfinder. About 29% of Washington residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Washington expanded Medicaid, effective January 1, 2014.

### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.

High-Performing
Average-Performing
Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- Washington requires exchange plans to offer catastrophic coverage options.
- Its effective rate review program allows the state to manage premium increases.[4]
- Ten carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Washington is a

High-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- Washington has plans to develop a quality rating system. Currently, the exchange displays health plans' quality improvement strategies to improve health outcomes, increase patient safety, and prevent hospital readmissions.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Washington is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[5]
- Washington expanded Medicaid, which now covers an estimated 445,000 people in the state.

For continutity-of-care metrics, relative to other states, Washington is an

Average-Performing State

## A MORE PATIENT-FOCUSED WASHINGTON MARKETPLACE

Washington has achieved some success in fostering a patient-focused market, as they have taken several state actions, beyond the federal requirements, that better protect patients.

However, Washington has not exercised its full authority to regulate the exchange market to promote patient protections. Through legislative or other state action, Washington could standardize benefit designs or plan benefit materials. The state has few platinum plans, which limits options for the people who would benefit most—those with chronic conditions and disabilities. Contracting requirements could encourage, or potentially require, carriers to offer a platinum plan. Since it is a state-based exchange, Washington could exert even more influence over the exchange by becoming an active purchaser. Finally, Washington could act to make the website more patient-focused with tools to make plan information standardized and more accessible.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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2 National Conference of State Legislatures, "Insurance Carriers and Access to Healthcare Providers: Network Adequacy," November 30, 2014, accessed via: http://www.ncsl.org/research/health/insurance-carriers-and-access-to-healthcare-providers-network-adequacy.aspx

3 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

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5 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

# West Virginia Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have taken extra steps to make their markets more patient-focused. This Progress Report measures a state across five principles to assess how well its insurance market is designed to meet the needs of people with chronic diseases and disabilities.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- West Virginia has no platinum offerings in the 2015 exchange.
- No state action on provider network requirements
- The premium for the 2nd lowest cost silver plan is 8% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, West Virginia is a

Low-Performing State

### TRANSPARENCY

**TO PROMOTE BETTER CONSUMER ACCESS TO INFORMATION ABOUT COVERED SERVICES AND COSTS IN EXCHANGE PLANS.**

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, West Virginia is a

Low-Performing State

### WEST VIRGINIA HIGHLIGHTS

West Virginia established a state-federal partnership exchange. The state is responsible for managing plan participation in the exchange. West Virginia residents use the federal exchange, HealthCare.gov, to compare and purchase coverage.

In the 2014 plan year, 19,900 West Virginians selected an exchange plan through HealthCare.gov. About 18% of West Virginia residents who are eligible for subsidized exchange coverage enrolled in an exchange plan in 2014.[1]

West Virginia expanded Medicaid effective January 1, 2014.

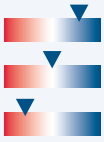
### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing

Average-Performing

Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Two carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, West Virginia is an

Average-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, West Virginia is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- West Virginia expanded Medicaid, which now covers an estimated 174,000 people in the state.

For continuity-of-care metrics, relative to other states, West Virginia is an

Average-Performing State

## A MORE PATIENT-FOCUSED WEST VIRGINIA MARKETPLACE

West Virginia has not exercised its full authority to regulate the exchange to promote patient protections. West Virginia's partial reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. West Virginia would have more control over exchange plans if the state opted to create a fully state-based exchange. West Virginia has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, West Virginia also could become an active purchaser. In addition, West Virginia's exchange does not foster competition as there are only two carriers offering coverage. As a result of the lack of competition and contracting requirements, there are no platinum plans offered in the state, limiting options for the people who would benefit most—those with chronic conditions and disabilities.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

# Wisconsin Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have taken extra steps to make their markets more patient-focused. This Progress Report measures a state across five principles to assess how well its insurance market is designed to meet the needs of people with chronic diseases and disabilities.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- Thirty-five unique platinum offerings in the 2015 exchange.
- No state action on provider network requirements.
- The premium for the 2nd lowest cost silver plan is 6% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Wisconsin is an

Average-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Wisconsin is a

Low-Performing State

### WISCONSIN HIGHLIGHTS

Wisconsin's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 139,800 Wisconsinites selected an exchange plan through HealthCare.gov. About 29% of Wisconsin's residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Wisconsin has not expanded Medicaid.

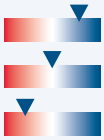
### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



High-Performing

Average-Performing

Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Its effective rate review program allows the state to manage premium increases.[3]
- Sixteen carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Wisconsin is an

Average-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Wisconsin is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Wisconsin has not expanded Medicaid, which would provide coverage for an estimated 53,000 people in the state.[5] Rather, Wisconsin has actually reduced the number of people in Medicaid by shifting some beneficiaries into exchanges with financial assistance to help pay monthly premiums.

For uniformity metrics, relative to other states, Wisconsin is a

Low-Performing State

## A MORE PATIENT-FOCUSED WISCONSIN MARKETPLACE

Wisconsin's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Wisconsin would have more control over exchange plans if the state opted to create a state-based exchange or, as an intermediary step, a partnership or exchange plan management exchange model. Wisconsin has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Wisconsin also could become an active purchaser, which could help the state better manage increasing premiums. Another critical step towards a patient-friendly health insurance market would be for Wisconsin to expand Medicaid, rather than shift people out of the program into the exchanges; this current practice imposes more of a cost-burden and in some instances more limited coverage. Expansion of Medicaid would provide health insurance for nearly 53,000 million Wisconsinites.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

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3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

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# Wyoming Progress Report

## STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

### OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have acted to make their markets more patient-focused. This scorecard evaluates states based on five key areas that assess patient-friendliness of their insurance markets to promote policies that best protect patients.

### FIVE PATIENT-FOCUSED PRINCIPLES

### NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- No state action to limit discrimination.
- Two unique platinum offerings in the 2015 exchange.
- No state action on provider network requirements.
- The premium for the 2nd lowest cost silver plan is 3% higher in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Wyoming is an

Average-Performing State

### TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Wyoming is a

Low-Performing State

### WYOMING HIGHLIGHTS

Wyoming's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 12,000 Wyomingites selected an exchange plan through HealthCare.gov. About 18% of Wyoming residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Wyoming has not expanded Medicaid.

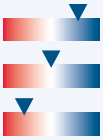
### PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- Beneficial for Patients
- Neutral for Patients
- Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



- High-Performing
- Average-Performing
- Low-Performing

## STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- No state action regarding contracting requirements for exchange participation.
- Wyoming does not have an effective rate review program.[3]
- Two carriers in the 2015 exchange market.

For state-oversight metrics, relative to other states, Wyoming is a

Low-Performing State

## UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- No state action to standardize benefit designs.
- The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Wyoming is an

Average-Performing State

## CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- No state action on continuity-of-care requirements.[4]
- Wyoming has not expanded Medicaid, which would provide coverage for an estimated 27,000 people in the state.[5]

For continuity-of-care metrics, relative to other states, Wyoming is a

Low-Performing State

## A MORE PATIENT-FOCUSED WYOMING MARKETPLACE

Wyoming has not exercised its full authority to regulate the exchange to promote patient protections. Wyoming's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Wyoming would have more control over exchange plans if the state opted to create a state-based exchange or, as an intermediary step, a partnership or exchange plan management model. Wyoming has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Wyoming also could become an active purchaser, which could help the state better manage increasing premiums. Further, the state has very few platinum plans, which limits options for the people who would benefit most—those with chronic conditions and disabilities. Contracting requirements could encourage, or potentially require, carriers to offer a platinum plan.

Another critical step towards a patient-friendly health insurance market would be for Wyoming to expand Medicaid. Expansion of Medicaid would provide health insurance for more than 27,000 Wyomingites.

## METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

For definitions of key terms, see the National Health Council's Putting Patients First® glossary.

1 Kaiser Family Foundation, "Estimated Number of Individuals Eligible for Financial Assistance through the Marketplaces," November, 2014, accessed via: http://kff.org/other/state-indicator/estimated-number-of-individuals-eligible-for-premium-tax-credits-through-the-marketplaces/

2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

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Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.


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June 2015 | Issue Brief

# Analysis of 2016 Premium Changes and Insurer Participation in the Affordable Care Act's Health Insurance Marketplaces

Cynthia Cox, Rosa Ma, Gary Claxton, Larry Levitt

## INTRODUCTION

Premium growth in the Affordable Care Act's Health Insurance Marketplaces has been an area of significant interest, as this is one of the most tangible and measurable indicators of whether the ACA is working to keep health insurance affordable. The ACA's rate review provision requires premium increases over ten percent to be made public. As a number of individual market insurers are requesting 2016 increases well above 10 percent, concern has been raised over the affordability of premiums in the coming year. However, these increases are not necessarily representative of the range of products from which consumers will be able to choose, and similar data is not widely available for the plans with moderate increases or decreases.

This brief presents an early analysis of changes in the premiums for the lowest- and second-lowest cost silver marketplace plans in major cities in 10 states plus the District of Columbia, where we were able to find complete data on rates for all insurers. It follows a similar approach to our September 2013 and 2014 analyses of Marketplace premiums.

In most of these 11 major cities, we find that the costs for the lowest and second-lowest cost silver plans – where the bulk of enrollees tend to migrate – are changing relatively modestly in 2016, although increases are generally bigger than in 2015. The cost of a benchmark silver plan in these cities is on average 4.4% higher in 2016 than in 2015. These premiums are still preliminary in some cases and could be raised or lowered through these states' rate review processes, and it is difficult to generalize to all states based on this small sample of states where all rate filings are available. We also find that the number of insurers participating has stayed the same or increased in 9 states, while insurer participation decreased in Michigan and the District of Columbia.

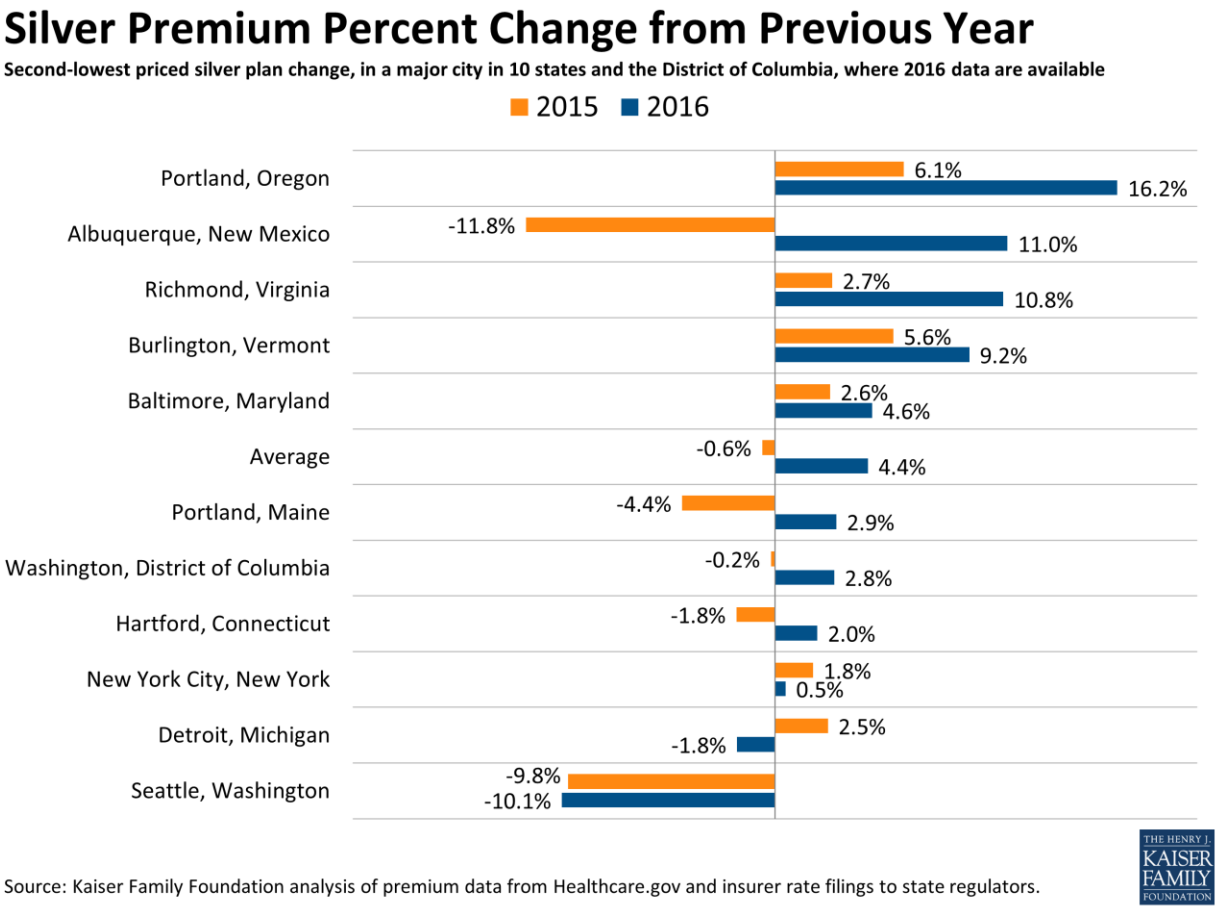
## APPROACH

In preparation for open enrollment for coverage in 2016, insurers filed premiums with state insurance departments. States vary in whether and when they release those filings. Our analysis is based on the 10 states plus the District of Columbia where we were able to find comprehensive filings or other information about the rates of the lowest-cost plans. Other states have released summary information, but not sufficient detail to identify the lowest-cost silver plans. In many cases, premiums are still under review by insurance departments and may change prior to the start of open enrollment.

We examine premiums in the rating area that includes a major city in each state. Premiums vary significantly within states, with the rating area being the smallest geographic unit by which insurers are allowed to vary rates. For each rating area, we look at premiums for the two lowest-cost silver plans. We focus on silver plans because they are the basis for federal premium subsidies and because these are the plans that most marketplace enrollees (68%) have chosen.

## Changes in Lowest Two Silver Plans

Across the 11 cities we examined, the premium for the second-lowest-cost silver plan in the Marketplace – before accounting for any tax credit – is increasing by an average of 4.4%. By contrast, in these cities, the average change in the benchmark silver plan was -0.6% from 2014 to 2015. (The nationwide average increase in this plan was 2% from 2014 to 2015).




Benchmark premium changes in 2016 vary significantly across the cities, ranging from a decrease of 10.1% in Seattle, Washington to an increase of 16.2% in Portland, Oregon.

| Table 1: Monthly Benchmark Silver Premiums for a 40 Year Old Non-Smoker Making $30,000 / Year | | | | | | | |
|---|---|---|---|---|---|---|---|
| State | Rating Area (Major City) | 2nd Lowest Cost Silver **Before** Tax Credit | | | 2nd Lowest Cost Silver **After** Tax Credit | | |
| | | 2015 | 2016 | % Change from 2015 | 2015 | 2016 | % Change from 2015 |
| Connecticut | 2 (Hartford) | $322 | **$328** | 2.0% | $208 | **$208** | 0.2% |
| DC | 1 (Washington) | $242 | **$248** | 2.8% | $208 | **$208** | 0.2% |
| Maine | 1 (Portland) | $282 | **$290** | 2.9% | $208 | **$208** | 0.2% |
| Maryland | 1 (Baltimore) | $235 | **$246** | 4.6% | $208 | **$208** | 0.2% |
| Michigan | 1 (Detroit) | $230 | **$226** | -1.8% | $208 | **$208** | 0.2% |
| New Mexico | 1 (Albuquerque) | $171 | **$190** | 11.0% | $171* | **$190*** | 11.0%* |
| New York | 4 (New York City) | $372 | **$374** | 0.5% | $208 | **$208** | 0.2% |
| Oregon | 1 (Portland) | $213 | **$248** | 16.2% | $208 | **$208** | 0.2% |
| Vermont | 1 (Burlington) | $436 | **$476** | 9.2% | $208 | **$208** | 0.2% |
| Virginia | 7 (Richmond) | $260 | **$288** | 10.8% | $208 | **$208** | 0.2% |
| Washington | 1 (Seattle) | $254 | **$228** | -10.1% | $208 | **$208** | 0.2% |
| **Average % change from 2015** | | | | **4.4%** | | | **1.2%** |

Source: Kaiser Family Foundation analysis of 2016 insurer rate filings to state regulators. Notes: Rates are not yet final and subject to review by the state. Oregon rates reflect preliminary changes from the state. *Unsubsidized Albuquerque premiums are so low that a 40 year old making $30,000 per year would not qualify for a premium tax credit in 2016

As shown in the final column of the above table, the amount paid by an enrollee after accounting for the premium tax credit will depend on his or her income and family size. In 2015, a 40-year-old single enrollee making $30,000 per year would have paid $208 per month in most areas of the country, and a similar person would pay approximately the same in 2015. (Although premium caps are increasing for 2016, the poverty guidelines are also changing such that a single person making $30,000 will be at a slightly lower percent of poverty than he or she would be this year. These two changes in effect cancel each other out, leaving monthly payments for the benchmark plan very similar from year-to-year.)

Similar patterns can be seen for the lowest-cost silver plan in each city. On average, the premium for the lowest-cost-silver plan in these cities is increasing by 4.5% from 2015 to 2016, ranging from a decrease of 4.2% in Seattle, Washington to an increase of 19.0% in Richmond, Virginia.

| Table 2: Monthly Lowest-Cost Silver Premiums for a 40 Year Old Non-Smoker Making $30,000 / Year | | | | | | | |
|---|---|---|---|---|---|---|---|
| State | Rating Area (Major City) | Lowest Cost Silver **Before** Tax Credit | | | Lowest Cost Silver **After** Tax Credit | | |
| | | 2015 | 2016 | % Change from 2015 | 2015 | 2016 | % Change from 2015 |
| Connecticut | 2 (Hartford) | $321 | **$327** | 1.9% | $207 | **$207** | 0.1% |
| DC | 1 (Washington) | $239 | **$244** | 2.1% | $205 | **$204** | -0.6% |
| Maine | 1 (Portland) | $275 | **$284** | 3.4% | $201 | **$202** | 0.7% |
| Maryland | 1 (Baltimore) | $226 | **$232** | 2.6% | $199 | **$194** | -2.2% |
| Michigan | 1 (Detroit) | $219 | **$210** | -4.2% | $197 | **$192** | -2.3% |
| New Mexico | 1 (Albuquerque) | $167 | **$186** | 11.5% | $167* | **$186*** | 11.5%* |
| New York | 4 (New York City) | $372 | **$369** | -0.7% | $207 | **$203** | -1.9% |
| Oregon | 1 (Portland) | $212 | **$228** | 7.7% | $207 | **$189** | -8.6% |
| Vermont | 1 (Burlington) | $428 | **$471** | 10.0% | $200 | **$203** | 1.6% |
| Virginia | 7 (Richmond) | $241 | **$287** | 19.0% | $189 | **$208** | 9.8% |
| Washington | 1 (Seattle) | $235 | **$225** | -4.2% | $189 | **$205** | 8.6% |
| **Average % change from 2015** | | | | **4.5%** | | | **1.5%** |

Source: Kaiser Family Foundation analysis of 2016 insurer rate filings to state regulators. Notes: Rates are not yet final and subject to review by the state. Oregon rates reflect preliminary changes from the state. *Unsubsidized Albuquerque premiums are so low that a 40 year old making $30,000 per year would not qualify for a premium tax credit in 2016

## Active Renewal and Premium Changes

As was the case last year, the plans that had the lowest premiums in 2015 were usually no longer one of the two lowest-cost silver plans in 2016. Among the 10 major cities where we could identify the product offered as the lowest and second-lowest silver plan, in only one city (Portland, Maine) would a person who signed up for either of the two lowest-cost silver plans in 2015 be able to stay in the same plan and still be enrolled in one of the two lowest silver plans in 2016.

| Table 3: Changes in Lowest-Cost Silver Products | | | |
|---|---|---|---|
| State | Rating Area (Major City) | Is the 2015 Lowest-Cost Silver Still One of Two Lowest Silvers in 2016? | Is the 2015 Second-Lowest-Cost Silver Still One of Two Lowest Silvers in 2016? |
| Connecticut | 2 (Hartford) | Yes | **No** |
| DC | 1 (Washington) | N/A* | N/A* |
| Maine | 1 (Portland) | Yes | Yes |
| Maryland | 1 (Baltimore) | Yes | **No** |
| Michigan | 1 (Detroit) | Yes | **No** |
| New Mexico | 1 (Albuquerque) | **No** | **No** |

| | | | |
|---|---|---|---|
| New York | 4 (New York City) | **No** | **No** |
| Oregon | 1 (Portland) | **No** | **No** |
| Vermont | 1 (Burlington) | Yes | **No** |
| Virginia | 7 (Richmond) | **No** | **No** |
| Washington | 1 (Seattle) | Yes | **No** |

Source: Kaiser Family Foundation analysis of 2016 insurer rate filings to state regulators
Notes: Rates are not yet final and subject to review by the state.
*The District of Columbia did not public sufficient detail to determine whether plans are the same as those offered in 2015, but the insurers are the same.

This underscores the importance of enrollees actively shopping each open enrollment period. For example, in Seattle, Washington, Bridgespan offered the second-lowest-cost silver plan in 2015 at a premium of $254 per month for a single 40 year-old before taking a tax credit into account. Bridgespan is increasing this plan's rate to $286 per month for 2016, but another insurer (Ambetter) is undercutting it and offering two lower-cost silver options for $225 and $228 per month. An unsubsidized person enrolled in the 2015 second-lowest silver plan offered by Bridgespan would see a 12.6% increase if she stayed in the same plan. Conversely, if she switched to the new second-lowest silver plan offered by Ambetter, her premium would drop -10.1% (before accounting for the relatively small effect aging up a year would have on her premiums).

The effect of changes in the benchmark premium relative to other plans is magnified for subsidized enrollees because the tax credit is tied to the premium for the second-lowest cost silver plan in a given year. If the same 40 year-old in the example above makes $30,000, she would be paying $208 per month in 2015 for the benchmark plan (offered by Bridgespan) and the federal government covers the rest through a tax credit. In 2016, if she switches to the new benchmark (offered by Ambetter), she would continue to pay $208 per month (assuming she continues to have the same income and family size in 2016). However, if she stayed in the Bridgespan plan, she would have to pay that amount plus the premium difference between the Bridgespan and Ambetter plans, or a total of approximately $266 (an increase of about 28%, before accounting for a relatively small increase resulting from aging one year). To keep her lower premium, she has to be willing to switch plans. Similar situations arise in the 9 cities where a low-cost insurer is raising its premiums faster than other carriers, or where a different insurer is offering lower premium.

In addition to switching plans, the person in the example above would also have to switch insurance companies in order to avoid a significant premium increase. Similar situations could arise for people enrolled in at least one of the two lowest-cost silver plans in 2015 in seven out of eleven major cities.

**Table 4: Changes in Insurers Offering the Lowest-Cost Silver Products**

| State | Rating Area (Major City) | Would person enrolled in 2015 Lowest-Cost Silver Have to Switch Insurers to Stay in One of Two Lowest Plans? | Would person enrolled in 2015 Second-Lowest-Cost Silver Have to Switch Insurers to Stay in One of Two Lowest Plans? |
|---|---|---|---|
| Connecticut | 2 (Hartford) | No | No |
| DC | 1 (Washington) | No | No |
| Maine | 1 (Portland) | No | No |
| Maryland | 1 (Baltimore) | No | **Yes** |
| Michigan | 1 (Detroit) | No | **Yes** |
| New Mexico | 1 (Albuquerque) | **Yes** | No |
| New York | 4 (New York City) | **Yes** | **Yes** |
| Oregon | 1 (Portland) | No | **Yes** |

| | | | |
|---|---|---|---|
| Vermont | 1 (Burlington) | No | No |
| Virginia | 7 (Richmond) | **Yes** | **Yes** |
| Washington | 1 (Seattle) | No | **Yes** |

Source: Kaiser Family Foundation analysis of 2016 insurer rate filings to state regulators
Notes: Rates are not yet final and subject to review by the state.

Although switching insurance carries could help stimulate competition in the exchange – which, to some extent, is how the premium tax credit is designed to work – changing insurance carriers can cause challenges for some enrollees, in particular potentially needing to change doctors (although staying with the same carrier from year-to-year does not necessarily guarantee a consistent network of doctors either).

## Insurer Participation

On average, 7 insurers (grouped by parent company) will offer coverage in these states in 2016, which is a similar number that participated in 2015 and an increase from 6 in 2014. Insurer participation has increased or remained stable in all of the states but Michigan, where the number dropped from 13 to 12 and the District of Columbia, where the number dropped from 3 to 2. The number of insurers participating in these states' Marketplaces ranges from 2 in Vermont and DC to 16 in New York.

**Table 5: Number of Insurers, Grouped by Parent Company, Participating in Marketplaces, 2014 – 2016**

| State | 2014 | 2015 | 2016 |
|---|---|---|---|
| Connecticut | 3 | 4 | 4 |
| DC | 3 | 3 | 2 (Aetna exited) |
| Maine | 2 | 3 | 4 (Aetna entered) |
| Maryland | 4 | 5 | 5 |
| Michigan | 9 | 13 | 12 (Assurant exited) |
| New Mexico | 4 | 5 | 6 (Centene entered) |
| New York | 16 | 16 | 16 |
| Oregon | 11 | 10 | 11 (Zoom Health entered) |
| Vermont | 2 | 2 | 2 |
| Virginia | 5 | 6 | 6 |
| Washington | 7 | 9 | 11 (UnitedHealth and Health Alliance entered) |
| **AVERAGE** | 6.0 | 6.9 | 7.2 |

Source: Kaiser Family Foundation analysis of 2016 insurer rate filings to state regulators
Notes: Filings are not yet final and subject to review by the state.

## Discussion

Premium changes for 2016 will vary substantially across areas and across insurers within a given region. At this time, with complete premium information only available in 10 states plus DC, and still awaiting final reviews by state regulators, it is too soon to draw conclusions about the premiums nationally. As a result of the ACA's rate review provision, data has become public on rate increases over 10 percent, with some insurers requesting average increases well into the double digits. However, the patterns in these 10 states and DC, where more complete information is available, suggest that the premiums for the two lowest-cost silver plans – where the

bulk of enrollees tend to migrate – are not necessarily increasing, and where they are increasing, the growth has generally been moderate.

As discussed in detail in our previous analysis, there are a variety of factors that may influence variations in premium changes, including the accuracy with which insurers had predicted their rates in 2014 and 2015, the composition of the risk pool, the steadiness of enrollment growth, and competitive dynamics. The proposed rates for 2016 represent the first year where insurers are able to set premiums based on actual claims experience for Marketplace enrollees. Even so, insurers only have annual data from 2014, which was incomplete (as most enrollees did not effectuate coverage until mid-year, whereas deductibles are annual) and not necessarily representative (as there was likely pent-up demand for health services among people who were previously uninsured).

Some of this remaining uncertainty is mitigated by the ACA's "3 R's" programs. These programs – risk adjustment, reinsurance, and risk corridors – redistribute risk among insurance carriers so that plans that enroll disproportionately sicker or higher-cost enrollees can be prevented from having to significantly raise premiums. However, two of these three programs (reinsurance and risk corridors) were only intended to be transitional, and reinsurance funding is phasing out from a maximum of $10 billion in 2014 to $4 billion in 2016. Another potential driver of 2016 premium increases is that the underlying cost of health care is expected to increase next year, particularly for prescription drugs.

Factors that could have a downward effect on premiums in 2016 include competitive forces (for which average growth in the number of insurers is a positive sign); increases in enrollment among the uninsured (which would bring healthier enrollees into the risk pool); and the movement of healthier enrollees from "grandmothered" plans into ACA-compliant plans either on- or off- of the exchange.

Finalized information on 2016 Marketplace premiums will become available for these and other states over the next few months, with complete information for all 50 states typically becoming public shortly before open enrollment, which begins November 1, 2015.

## METHODS

Data were collected from health insurer rate filing submitted to state regulators. These submissions are publicly available for the states we analyzed. Most rate information is available in the form of a SERFF filing (System for Electronic Rate and Form Filing) that includes a base rate and other factors that build up to an individual rate. In states where filings were unavailable, we gathered data from tables released by state insurance departments. Filings are still preliminary. All premiums in this analysis are at the rating area level, and some plans may not be available in all cities or counties within the rating area. Rating areas are typically groups of neighboring counties, so a major city in the area was chosen for identification purposes.

Department of Health and Human Services

**OFFICE OF INSPECTOR GENERAL**

# CMS'S INTERNAL CONTROLS DID NOT EFFECTIVELY ENSURE THE ACCURACY OF AGGREGATE FINANCIAL ASSISTANCE PAYMENTS MADE TO QUALIFIED HEALTH PLAN ISSUERS UNDER THE AFFORDABLE CARE ACT

*Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.*

Daniel R. Levinson
Inspector General

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http://oig.hhs.gov

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## OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

## EXECUTIVE SUMMARY

***CMS's internal controls (i.e., processes in place to prevent or detect any possible substantial errors) did not effectively ensure the accuracy of nearly $2.8 billion in aggregate financial assistance payments made to insurance companies under the Affordable Care Act during the first 4 months that these payments were made.***

## WHY WE DID THIS REVIEW

The Patient Protection and Affordable Care Act (ACA) established health insurance exchanges (commonly referred to as "marketplaces") to allow individuals and small businesses to shop for health insurance in all 50 States and the District of Columbia. A marketplace allows insurance companies (issuers) to offer individuals private health insurance plans, known as qualified health plans (QHPs), and enrolls individuals in those plans. The Centers for Medicare & Medicaid Services (CMS) operates the Federal marketplace and is responsible for reviewing, approving, and generating financial assistance payments (i.e., advance premium tax credits (APTCs) and advance cost-sharing reductions (CSRs)) for the Federal and State-based marketplaces. Our review covered the period from January 1, 2014, to April 30, 2014, during which CMS was using an interim process for approving financial assistance payments.

The ACA vested in the Department of Health and Human Services substantial responsibilities for increasing access to health insurance for those who are eligible for coverage, improving access to and the quality of health care, and lowering health care costs and increasing value for taxpayers and patients. This report is part of a broader portfolio of Office of Inspector General reviews examining various aspects of marketplace operations, including payment accuracy, eligibility verifications, management and administration, and data security.

The objective of this review was to determine whether CMS's internal controls were effective to ensure the accuracy of financial assistance payments to QHP issuers made during the first 4 months that these payments were made.

## BACKGROUND

### Health Insurance Marketplaces

A marketplace is designed to serve as a one-stop shop at which individuals get information about their health insurance options; are evaluated for eligibility for a QHP and, when applicable, eligibility for financial assistance payments; and enroll in the QHP of their choice. QHPs are grouped into four "metal levels": bronze, silver, gold, and platinum. An issuer may offer multiple QHPs through a marketplace.

Individuals in States without a State-based marketplace (State marketplace) could choose a QHP through the CMS-administered Federal marketplace. States were also able to establish State-partnership marketplaces in which they shared responsibilities for core functions with CMS. As of December 17, 2014, 34 States, including 7 State-partnership marketplaces, used the Federal marketplace, and the other 17 States had State marketplaces.

**CMS's Process for Reviewing, Approving, and Generating Financial Assistance Payments to Qualified Health Plan Issuers**

The ACA provides financial assistance payments to lower certain enrollees' insurance premiums or out-of-pocket insurance costs or both. The Federal Government distributes financial assistance payments to QHP issuers on behalf of eligible enrollees:

- **Advance Premium Tax Credits (APTCs)**: APTCs are advance payments of premium tax credits (PTCs). APTCs assist certain low-income enrollees with the cost of their premiums. For enrollees determined eligible for APTCs, the applicable marketplace determines the APTC amounts using the price of the second-lowest-priced silver-level plan available in the area in which the enrollees reside and the enrollees' reported income and family size. Eligible enrollees may opt to enroll in any plan, regardless of metal level.

- **Advance Cost-Sharing Reductions**: CSRs assist certain low-income enrollees with their out-of-pocket costs. To receive CSRs, eligible enrollees must enroll in a silver-level plan, which generally covers 70 percent of covered medical services costs. CSRs assist these enrollees in paying a portion of their remaining costs. The Federal Government makes an advance monthly CSR payment to QHP issuers to cover the issuers' estimated CSR costs.

QHP issuers cannot receive financial assistance payments unless CMS certifies their plans through CMS's vendor management process. CMS uploads information for certified plans to its financial management and accounting system. CMS personnel then access U.S. Department of the Treasury (Treasury) systems to allow Treasury to transmit CMS-authorized payments to QHP issuers.

Under CMS's interim process for approving financial assistance payments in effect during our audit period, issuers submitted to CMS a monthly "Enrollment and Payment Data Template" (template) covering enrollees in all of the issuers' plans. Each template contained the aggregate financial assistance amounts that the issuer submitted for reimbursement on the basis of its confirmed enrollment totals. Confirmed enrollees were defined as those who had paid their first month's premium to the QHP issuer and had their enrollment information approved by the issuer.

Under its interim process, CMS required QHP issuers to submit attestation agreements stating that all template information was accurate and in compliance with Federal policies and regulations before CMS processed their payments. CMS officials stated that they plan to implement a permanent process to authorize payments to issuers by automating enrollment and payment data on an enrollee-by-enrollee basis in late 2015.

### CMS's Methodology for Calculating Advance Cost-Sharing Reduction Payment Rates

CMS calculated advance CSR payment rates before QHP issuers began covering enrollees in January 2014. The rates were based on issuers' projected claims cost information for their plans, in conjunction with CMS guidance. Specifically, marketplaces submitted to CMS index rates that represented projected costs for their plans. CMS then multiplied the index rates by a CMS-derived utilization factor. CMS then multiplied the result by the difference between each particular plan's standard coverage rate (e.g., 70 percent for silver plans) and the plan's actual coverage rate (e.g., 73 percent for some CSR silver plans). From this three-part calculation, CMS derived the CSR payment rate to be applied for each confirmed, eligible enrollee in a particular CSR plan for calendar year 2014.

## HOW WE CONDUCTED THIS REVIEW

We reviewed financial assistance payments totaling approximately $2.8 billion authorized by CMS to QHP issuers for the period January 1, 2014, through April 30, 2014, under CMS's interim process. Of this amount, we reviewed a random sample of 100 payee group-months totaling approximately $302 million reimbursed to QHP issuers. A payee group-month is defined as all financial assistance payments made for a group of QHP issuers under one taxpayer identification number of a parent entity for 1 month. We reviewed CMS's internal controls for (1) certifying QHP issuers as qualified to receive financial assistance payments, (2) calculating advance CSR payment rates, (3) collecting financial assistance payment data from QHP issuers, and (4) transmitting financial assistance payment information to Treasury.

## WHAT WE FOUND

We determined that CMS's internal controls (i.e., processes put in place to prevent or detect any possible substantial errors) for calculating and authorizing financial assistance payments were not effective. Specifically, we found that CMS:

- relied on issuer attestations that did not ensure that advance CSR payment rates identified as outliers were appropriate,
- did not have systems in place to ensure that financial assistance payments were made on behalf of confirmed enrollees and in the correct amounts,
- did not have systems in place for State marketplaces to submit enrollee eligibility data for financial assistance payments, and
- did not always follow its guidance for calculating advance CSR payments and does not plan to perform a timely reconciliation of these payments.

The internal control deficiencies that we identified limited CMS's ability to make accurate payments to QHP issuers. On the basis of our sample results, we concluded that CMS's system of internal controls could not ensure that CMS made correct financial assistance payments during the period January through April 2014. With respect to advance CSR payments, we identified

both overpayments and underpayments. During our audit period, advance CSRs were paid at a fixed rate per enrollee. Because the issuer templates included aggregate enrollment numbers, we could determine whether the aggregate advance CSR amounts authorized were correctly computed given the aggregate information provided. This does not mean that on an enrollee-by-enrollee basis all advance CSR payments were correctly determined.

With respect to APTC payments, because CMS obtains APTC payment data from QHP issuers on only an aggregate basis, it is unable to verify the amounts requested through QHP issuers' attestations on an enrollee-by-enrollee basis. Unlike advance CSR payments, APTC amounts vary by enrollee. Thus, CMS cannot ensure that APTC payment amounts were appropriately applied on behalf of confirmed enrollees. Further, CMS's lack of APTC payment data on an enrollee-by-enrollee basis affected our ability in this review to identify any potential overpayments and underpayments related to APTC payments at the individual level.

Without effective internal controls for ensuring that financial assistance payments are calculated and applied correctly, a significant amount (approximately $2.8 billion) of Federal funds are at risk (e.g., there is a risk that funds were authorized for payment to QHP issuers in the incorrect amounts). Our review focused on the effectiveness of CMS's internal controls and, for the aforementioned reasons, did not verify whether these Federal funds were accurately applied on behalf of confirmed enrollees on an enrollee-by-enrollee basis.

We note that CMS has the responsibility to verify that financial assistance payments made to QHP issuers are accurate. CMS also has the authority to (1) require QHP issuers to restate enrollment totals and payment amounts for prior months to reflect prior inaccurate payments and (2) recoup these payments by offsetting them against future payments or other means. Because CMS has not developed the systems to obtain enrollment and payment information on an enrollee-by-enrollee basis, CMS cannot verify the accuracy of the nearly $2.8 billion it authorized for financial assistance payments during our audit period. We plan to conduct an additional review that will address financial assistance payments on an enrollee-by-enrollee basis. The planned review will include the audit period covered by this review and collect information necessary to determine payment accuracy.

## WHAT WE RECOMMEND

We recommend that CMS correct these internal control deficiencies by:

1. requiring its Office of the Actuary to review and validate QHP issuers' actuarial support for index rates used to calculate advance CSR payment rates that CMS identifies as outliers,

2. implementing computerized systems to maintain confirmed enrollee and payment information so that CMS does not have to rely on QHP issuers' attestations in calculating payments,

3. implementing a computerized system so State marketplaces can submit enrollee eligibility data,

4. following its guidance for calculating estimated advance CSR payments, and

5. developing interim reconciliation procedures to address potentially inappropriate CSR payments.

## CMS COMMENTS AND OUR RESPONSE

In written comments on our draft report, CMS concurred with our second, third, and fifth recommendations. CMS generally agreed with our first and fourth recommendations but indicated that the recommendations are no longer applicable because of regulatory action. CMS stated that it conducted an internal controls review over its financial reporting that determined its processes to be effective. In addition, an independent accounting firm conducted a similar review and reported no significant issues.

Regarding our first recommendation (requiring the Office of the Actuary to review and validate QHP issuers' actuarial support for index rates used to calculate advance CSR payment rates that CMS identified as outliers), CMS stated that it took regulatory action that eliminated the use of index rates in calculating advance CSR payment rates. As such, CMS stated that the Office of the Actuary will not need to review CMS's modified methodology for calculating these rates. CMS indicated that its regulatory action also affected our fourth recommendation—that CMS follow its own guidance for calculating estimated advance CSR payments. Specifically, CMS stated that for the 2015 benefit year, marketplaces now calculate the advance CSR payment amount for a specific policy as the product of the total monthly premium for that policy and a CSR plan "variation multiplier."

After reviewing CMS's comments, we maintain that our findings and recommendations are valid. CMS's regulatory action may appropriately address the findings related to our first and fourth recommendations. However, we have not tested the new advance CSR payment calculation described in the regulation. Therefore, we cannot determine whether the new calculation methodology allows for the type of discrepancies we identified during our audit period. Regarding the independent accounting firm's review of CMS's financial reporting, we note that the accounting firm's review tested basic transactions and security vulnerabilities. Further, the accounting firm reported findings related to advance CSR payments similar to those in this report.

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# INTRODUCTION

## WHY WE DID THIS REVIEW

The Patient Protection and Affordable Care Act (ACA) established health insurance exchanges (commonly referred to as "marketplaces") to allow individuals and small businesses to shop for health insurance in all 50 States and the District of Columbia. A marketplace allows insurance companies (issuers) to offer individuals private health insurance plans, known as qualified health plans (QHPs), and enrolls individuals in those plans. QHPs must meet certain participation standards and cover a core set of benefits. Appendix A provides a glossary of selected terms used in this report.

The Centers for Medicare & Medicaid Services (CMS) operates the federally-facilitated marketplace (Federal marketplace) and is responsible for reviewing, approving, and generating financial assistance payments (i.e., advance premium tax credits (APTCs) and advance cost-sharing reductions (CSRs)) for the Federal and State-based marketplaces. Under the ACA, individuals who enroll in QHPs may be eligible for one or both of two types of financial assistance: premium tax credits (PTCs) and CSRs. CMS had developed what it described as an interim process for approving these financial assistance payments and is expecting to implement a permanent process in late 2015. Our review covered the period from January 1, 2014, to April 30, 2014, during which CMS was using that interim process.

The Office of Inspector General (OIG) is focused on fighting fraud, waste, and abuse and promoting the economy, efficiency, and effectiveness of the ACA programs across the Department of Health and Human Services (the Department). The ACA vested in the Department substantial responsibilities for increasing access to health insurance for those who are eligible for coverage, improving access to and the quality of health care, and lowering health care costs and increasing value for taxpayers and patients. This report is part of a broader portfolio of OIG reviews examining various aspects of marketplace operations, including payment accuracy, eligibility verifications, management and administration, and data security. Appendix B contains details on OIG's related work.

## OBJECTIVE

Our objective was to determine whether CMS's internal controls were effective to ensure the accuracy of financial assistance payments to QHP issuers made during the first 4 months that these payments were made.

## BACKGROUND

### Health Insurance Marketplaces

A marketplace is designed to serve as a one-stop shop at which individuals get information about their health insurance options; are evaluated for eligibility for a QHP and, when applicable, eligibility for financial assistance payments; and enroll in the QHP of their choice. QHPs are grouped into four "metal levels": bronze, silver, gold, and platinum. These levels determine the percentage that each QHP can expect to pay, on average, for the overall costs of providing

essential health benefits to its plan members. An issuer may offer multiple QHPs through a marketplace.

Individuals in States without a State-based marketplace (State marketplace) could choose a QHP through the CMS-administered Federal marketplace. States were also able to establish State-partnership marketplaces in which they shared responsibilities for core functions with CMS. As of December 17, 2014, 34 States, including 7 State-partnership marketplaces, used the Federal marketplace, and the other 17 States were using established State marketplaces.

**Roles and Responsibilities of CMS Offices**

Within the Department, CMS is the agency with primary responsibility for implementing and overseeing Title I of the ACA through four components: the Center for Consumer Information and Insurance Oversight (CCIIO), the Office of Financial Management (OFM), the Office of the Actuary (OACT), and the Office of Information Systems (OIS).

*Center for Consumer Information and Insurance Oversight*

CCIIO oversees implementation of ACA marketplace provisions and provides national leadership in setting and enforcing standards for private health insurers that participate in the marketplaces.[1] CCIIO was responsible for establishing the Federal marketplace and for assisting States in establishing their own marketplaces. CCIIO is also responsible for calculating and approving financial assistance payments to QHP issuers.

*Office of Financial Management*

OFM prepares CMS financial statements and works with other components to reconcile all CMS financial data. OFM maintains all payment data within CMS's Healthcare Integrated and General Ledger Accounting System (HIGLAS) and submits external payment activity reports to the U.S. Department of the Treasury (Treasury).

*Office of the Actuary*

OACT directs CMS's actuarial program. OACT created for CCIIO a formula for identifying payment rate outliers. OACT created this formula for CCIIO to identify potentially inappropriate index rates. (Index rates are an issuer's average projected gross claims costs across all plans offered within an individual State.)

[1] In this report, we refer to the Department to acknowledge activities related to the marketplaces that were undertaken by the Office of Consumer Information and Insurance Oversight (OCIIO), which was originally established in the Office of the Secretary; the Center for Consumer Information and Insurance Oversight (CCIIO) within CMS, to which OCIIO's responsibilities were transferred in early 2011.

*Office of Information Systems*

OIS is responsible for managing CMS's information technology infrastructure, including the Federal marketplace. OIS also operates most of the ACA-related automated controls, such as those over data file integrity and data file sharing.

## Types of Financial Assistance Payments

The ACA provides for financial assistance payments to lower certain enrollees' insurance premiums or out-of-pocket insurance costs or both. The Federal Government distributes financial assistance payments to QHP issuers on behalf of eligible enrollees:[2]

- **Advance Premium Tax Credits**: APTCs are advance payments of PTCs.[3,4] PTCs reduce the cost of plan premiums and are available at tax filing time or in advance. Generally, PTCs are available on a sliding scale to individuals or families with incomes from 100 through 400 percent of the Federal poverty level.[5] If a marketplace determines that an enrollee is eligible for a PTC, it determines the amount of the financial assistance payment on the basis of (1) the premium associated with the second-lowest-priced silver plan available in the area in which the enrollee resides and (2) the enrollee's reported income and family size. Eligible enrollees may opt to enroll in any plan, regardless of metal level. Taxpayers must include on their tax returns the amount of any APTC made on their behalf. The Treasury's Internal Revenue Service (IRS) is responsible reconciling APTC payments with the maximum allowable amount of the credit through enrollees' tax returns.[6]

- **Advance Cost-Sharing Reductions**: CSRs help qualifying individuals with out-of-pocket costs, such as deductibles, coinsurance, and copayments.[7] Generally, an

[2] For the purpose of this report, the term "enrollee" refers to an applicant who has completed an application, was determined eligible, and has selected a QHP and whose enrollment information was sent to a QHP issuer.

[3] ACA §§ 1401, 1412 and 45 CFR § 155.20 (definition of "advance payment of the premium tax credit").

[4] The Federal Government pays the APTC monthly to the QHP issuer on behalf of the enrollee to offset a portion of the cost of the premium. For example, if an enrollee who selects an insurance plan with a $500 monthly insurance premium qualifies for a $400 monthly APTC (and chooses to use it all as an advance payment), the enrollee pays only $100 to the QHP issuer. The Federal Government pays the remaining $400 to the QHP issuer.

[5] An individual or family with income below 100 percent of the Federal poverty level may be eligible for Medicaid under the State's Medicaid rules but would not qualify for the premium tax credit or cost-sharing reductions.

[6] The maximum allowable amount of the credit is the total amount of the PTC for which an individual may be eligible in a benefit year (26 U.S.C. §§ 36B(a) and (b)). Enrollees may elect to receive any portion of the maximum allowable amount of the credit.

[7] For example, an individual who visits a physician may be responsible for a $30 copayment. If the individual qualifies for a CSR of $20 for the copayment, the individual pays only $10. The Federal Government pays the remaining $20.

individual or family is eligible for CSRs if their household income is from 100 through 250 percent of the Federal poverty level. To receive CSRs, eligible enrollees must enroll in a silver-level plan,[8] which generally covers 70 percent of covered medical services costs. CSRs assist these enrollees in paying a portion of their remaining costs. The Federal Government makes an advance CSR monthly payment to QHP issuers to cover their estimated CSR costs.[9] Initially, CMS planned to reconcile with the QHP issuers the total amount of advance CSR payments made to the issuers and the actual CSR costs incurred at the end of each calendar year. In February 2015, CMS announced that it will postpone the reconciliation of CSR payments until April 2016. [10]

**Process for Qualifying Issuers To Receive Financial Assistance Payments**

Marketplaces must offer only health plans that meet certification requirements.[11] In order to be certified, each issuer must submit information such as its organizational structure, plan identifiers and attributes (e.g., metal-level category, geographic coverage), and support for the plan's premium rates. Each issuer must also meet requirements related to the administration of APTCs and CSRs (e.g., payment, allocation, and reconciliation of APTCs and CSRs).[12] CMS certifies issuers offering plans through the Federal marketplace, and State agencies certify information for issuers offering plans through State marketplaces. State agencies are responsible for sending certified information to CMS.

Once an issuer's information is certified, CMS obtains and verifies the issuer's payee and banking information and uploads it to CMS's financial management and accounting system, HIGLAS. CMS then creates a payee record for each issuer in an approved vendor list (vendor master file). CMS uses the vendor master file to ensure that QHP issuers have been approved to offer plans through the marketplaces, are qualified to receive financial assistance payments, and appropriate information for making payments is in the system.

After payee records are created in the vendor master file, CMS assigns payee identification numbers (payee group IDs) to establish what are known as "parent-child company groupings." CMS uses these groupings to organize issuers under the same tax identification number (TIN) for payment purposes (parent entities). Each such group has a unique payee group ID that represents a particular group of QHP issuers under the parent entity.

[8] American Indians and Alaska Natives are eligible for CSRs if their household income does not exceed 300 percent of the Federal poverty level. These individuals can enroll in any metal level plan to receive CSRs (45 CFR § 155.350(a)).

[9] CMS makes these advance CSR payments to protect QHP issuers from being required to bear the entire financial burden of providing CSRs over a benefit year (78 Fed. Reg. 15410, 15486 (March 11, 2013)).

[10] *Timing of Reconciliation of Cost-Sharing Reductions for the 2014 Benefit Year* (February 13, 2015).

[11] ACA § 1311(c); 45 CFR § 155.1000(b).

[12] 45 CFR § 156.215.

CMS allows parent entities to determine the number of payee groups and the issuers (child entities) associated with each group. This allows a parent entity to set up its payee groups according to how it prefers to be paid, because payments are made at the payee group level. Table 1 (below) provides an example of how a parent entity may set up its payee groups; in this example, XYZ Inc., has grouped itself to receive three payments for its six QHP issuers.

CMS approves and uploads payee group information from the vendor master file to HIGLAS, enabling CMS to process financial assistance payments to qualified issuers.

**Table 1: Example of Payee Grouping for XYZ Inc.**

| Parent Entity | QHP Issuer Name | Payee Group ID (How Parent Entity is Paid) |
|---|---|---|
| XYZ Inc. | 123 North | XYZ 1 |
| XYZ Inc. | 123 South | XYZ 1 |
| XYZ Inc. | 123 Central | XYZ 1 |
| XYZ Inc. | 123 East | XYZ 2 |
| XYZ Inc. | 123 Midwest | XYZ 3 |
| XYZ Inc. | 123 West | XYZ 3 |

## CMS's Methodology for Calculating Advance Cost-Sharing Reduction Payment Rates

CMS calculated advance CSR payment rates before QHP issuers began covering enrollees in January 2014. The rates were based on issuers' projected claims cost information for their plans, in conjunction with CMS guidelines. Issuers used a unified rate review template (URRT) containing index rates that represented projected cost information for their plans.[13] CMS then multiplied the applicable index rates by a CMS-derived utilization factor.[14] CMS then multiplied the result by the difference between the standard silver-level coverage rate (e.g., 70 percent) and the plan's actual coverage rate (e.g., 73 percent for some CSR silver plans).

Figure 1 provides the formula that CMS used to calculate estimated advance CSR payment rates applied for each confirmed enrollee in a particular plan for calendar year (CY) 2014.

**Figure 1: Advance CSR Payment Rate Formula**

Applicable index rate × utilization factor ×
(actual coverage rate − standard coverage rate)

See the example (Figure 2, next page) for how CMS used its three-part calculation to derive the CSR payment rate for one plan.

[13] In cases in which an issuer did not submit a URRT or CMS did not validate the index rate provided through the URRT, the State average index rate was used in the advance CSR payment rate calculation.

[14] 78 Fed. Reg. 15410, 15487 (March 11, 2013).

**Figure 2: Example of How CMS Calculated an Advance CSR Payment Rate**

An issuer submitted an index rate for a silver-level QHP with an actual coverage rate that covered approximately 87 percent of covered medical costs. The index rate indicated that the projected cost per member per month was $606.75. The utilization factor for a silver-level QHP with an actual coverage rate covering approximately 87 percent of covered medical costs is 1.12, a figure derived by CMS. The plan's actual coverage rate for covered medical costs is 87 percent, with the standard coverage rate for a typical silver-level plan being 70 percent.

By applying the formula described in Figure 1, the advance CSR payment rate for this QHP would be $115.53, which would be applied to every confirmed enrollee monthly.

*Silver-Level QHP With an Actual Coverage Rate of 87 Percent*
*$606.75 × 1.12 × (0.87 – 0.70) = $115.53*

## Planned and Interim Processes for Collecting Financial Assistance Payment Data

Before the health insurance marketplaces opened, CMS elected to electronically transfer health insurance information between QHP issuers, marketplaces, and CMS through what are called "834 transactions."[15] Upon applying for health care coverage through the marketplaces, applicants would select their QHP, and the marketplace would determine the amount of any financial assistance payments that applicants were eligible to receive. Once an application was completed, an initial 834 transaction containing the calculation for any applicable financial assistance amount would be sent from the marketplace to the selected QHP.[16] State marketplaces were then required to share the initial 834 transactions with CMS and update these data monthly. CMS, in its role as administrator of the Federal marketplace, maintains initial 834 transactions for enrollees who have applied for health insurance coverage through the Federal marketplace.

Under CMS's initial design of the financial assistance payment process, once QHP issuers received the initial 834 transactions, they were required to review the data in the application and ensure that enrollees paid their portion of the first month's premium (premium amount less APTC).[17] The QHP issuer was then to send a confirmation 834 transaction to the QHP issuer's

[15] "834 transactions" are electronic files used by CMS to share health insurance information between QHP issuers, marketplaces, and CMS. A "confirmation 834 transaction" is created after the QHP issuer reviews the data in the application and ensures that enrollees paid their portion of the first month's premium (premium amount less APTC) to receive any financial assistance payments.

[16] An "initial 834 transaction" contains the calculation for any applicable financial assistance amounts that would be sent from the marketplace to the selected QHP issuer.

[17] Enrollees must pay their share of the first month's premium to be covered by the QHP and to receive any financial assistance (45 CFR § 155.400(e)).

respective marketplace, confirming enrollment and payment of the premium.[18] The marketplaces were to share confirmation enrollment data with CMS and update the information monthly. On the basis of the confirmed enrollment data provided by the marketplaces, CMS would then pay financial assistance payments and provide a monthly report to QHP issuers.

Because CMS had not yet developed the necessary computerized systems in accordance with the initial design to share confirmation 834 transactions for individual enrollees, CMS developed an interim process for approving financial assistance payments to QHP issuers on an aggregate basis. CMS officials stated that they plan to implement a permanent process to authorize payments to issuers by automating enrollment and payment data on an enrollee-by-enrollee basis in late 2015.

Under the interim process, CMS requires QHP issuers to submit an "Enrollment and Payment Data Template" (template) aggregating the confirmed enrollment and advance totals for financial assistance payments covering enrollees in all of the issuers' plans. The aggregate data contain only enrollment and payment totals that QHP issuers maintain from each individual enrollee's confirmation 834 transaction. The aggregate data on the template do not contain detailed information on the individual enrollees along with their associated financial assistance payment amounts. The templates are submitted to CMS between the 16th and 23rd of each month and consist of aggregated enrollment totals for confirmed enrollees as of the 15th of that month. CMS authorizes payments during the subsequent month (e.g., after January 16th, QHP issuers send CMS the February templates with enrollment information as of January 15th, and CMS authorizes payments in February). Issuers may also revise enrollment and payment information for all prior months. Along with each template, QHP issuers submit an attestation agreement stating that all aggregate information included in the template is accurate. CMS policy states that CMS will not issue financial assistance payments to QHP issuers if the attestation is not provided.

**Process for Transmitting Financial Assistance Payments**

After obtaining payment information via the templates, CMS uploads it to HIGLAS and begins generating reports that organize payments into their pre-established payee groups. CMS then transmits payment invoices to Treasury via a payment schedule, accesses Treasury's Secure Payment System (SPS), and completes the necessary payment reports in the SPS. Finally, CMS certifies that the information entered in Treasury's SPS was accurate, and Treasury makes the financial assistance payments to the applicable payee groups.

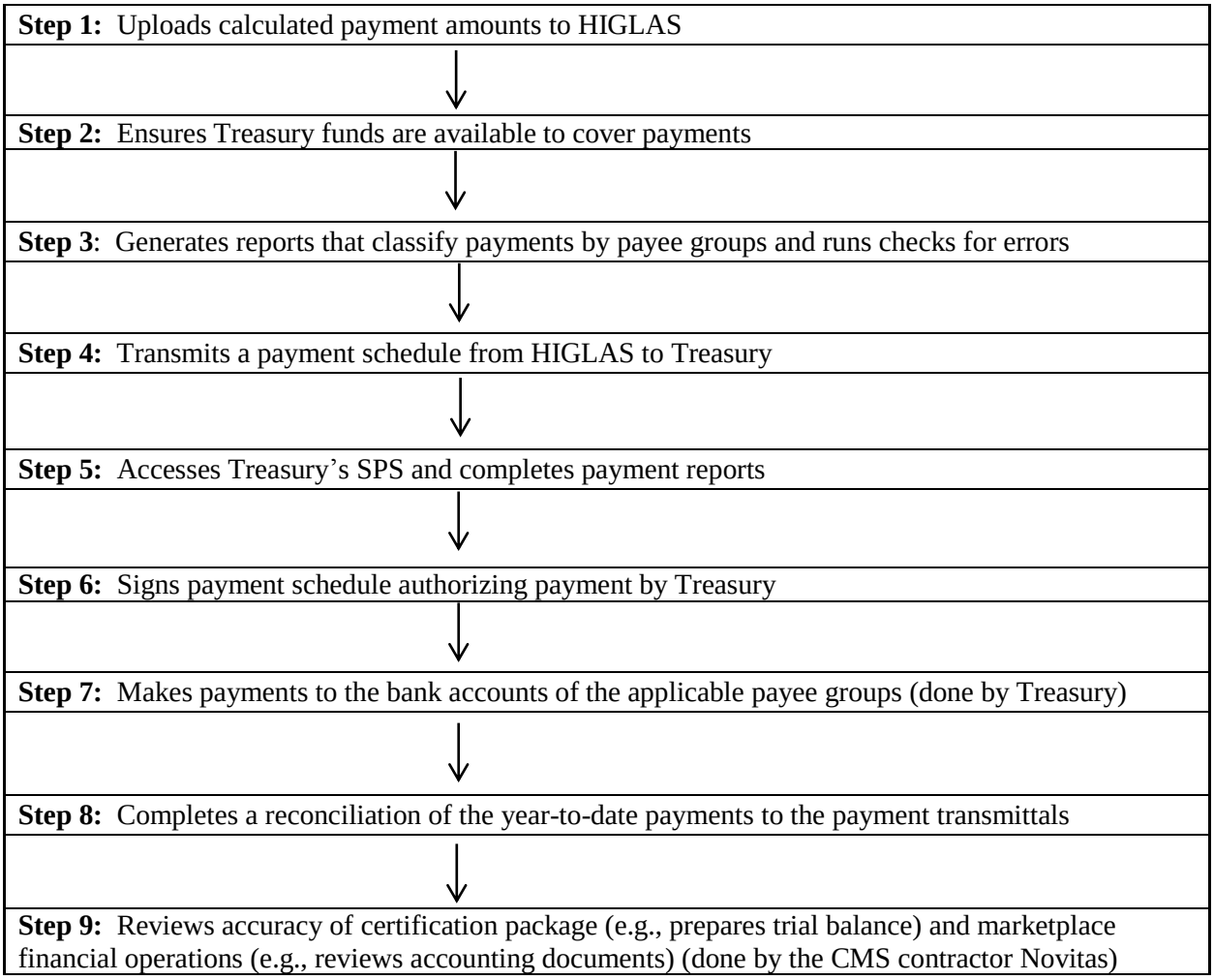
CMS creates and certifies a reconciliation of payments as evidence that a review was performed to ensure that marketplace payments (on a year-to-date basis) posted on the CMS general ledger, HIGLAS, reconcile to the payment transmittals.[19] CMS has contracted with Novitas Solutions,

[18] A "confirmation 834 transaction" is created after the QHP issuer reviews the data in the application and ensures that enrollees paid their portion of the first month's premium (premium amount less APTC) in order to receive any financial assistance payments.

[19] This is a different reconciliation than the one previously discussed for comparing the amount of advance CSR payments made to the actual CSR costs incurred. This reconciliation is intended to ensure that payment records match amounts recorded in the accounting system.

Inc. (Novitas), to oversee CMS's administration of certain marketplace functions, assist it in reporting CMS's financial position, reconcile CMS financial records to HIGLAS, and prepare a trial balance of all marketplace-related ledgers to detect any errors. Novitas also attests to the accuracy of the information reported on the statement of financial position related to marketplace operations[20] at the end of each month. Figure 3 (below) illustrates CMS's steps for transmitting financial assistance payments.

**Figure 3: CMS's Steps for Transmitting Financial Assistance Payments**




## HOW WE CONDUCTED THIS REVIEW

We reviewed financial assistance payments totaling approximately $2.8 billion made to QHP issuers for the period January 1, 2014, through April 30, 2014, under CMS's interim process. Of this amount, we reviewed a random sample of 100 payee group-months totaling approximately $302 million reimbursed to QHP issuers. A payee group-month is defined as all financial

[20] This statement reflects the overall financial position (assets minus liabilities) of CMS's marketplace operations at a given moment in time.

assistance payments made for a group of QHP issuers under one TIN of a parent entity for 1 month.

The scope of our audit did not include analyses of enrollee eligibility or the accuracy of calculations of actual financial assistance payments claimed for reimbursement. Rather, we limited our review to CMS's internal controls for determining advance payment amounts and processing payments to QHP issuers. Specifically, we reviewed CMS's internal controls for (1) certifying QHP issuers as qualified to receive financial assistance payments, (2) calculating advance CSR payment rates, (3) collecting financial assistance payment data from QHP issuers, and (4) transmitting financial assistance payment information to Treasury.

Appendix C contains the details of our audit scope and methodology, Appendix D contains our statistical sampling methodology, and Appendix E contains our sample results and estimates.

## FINDINGS

We determined that CMS's internal controls (i.e., processes put in place to prevent or detect any possible substantial errors) for calculating and authorizing financial assistance payments were not effective. Specifically, we found that CMS:

- relied on issuer attestations that did not ensure that advance CSR payment rates identified as outliers were appropriate,

- did not have systems in place to ensure that financial assistance payments were made on behalf of confirmed enrollees and in the correct amounts,

- did not have systems in place for State marketplaces to submit enrollee eligibility data for financial assistance payments, and

- did not always follow its guidance for calculating advance CSR payments and does not plan to perform a timely reconciliation of these payments.

The internal control deficiencies that we identified limited CMS's ability to make accurate payments to QHP issuers. On the basis of our sample results, we concluded that CMS's system of internal controls could not ensure that CMS made correct financial assistance payments during the period January through April 2014. With respect to advance CSR payments, we identified both overpayments and underpayments. During our audit period, advance CSRs were paid at a fixed rate per enrollee. Because the issuer templates included aggregate enrollment numbers, we could determine whether the aggregate CSR amounts authorized were correctly computed given the aggregate information provided. This does not mean that on an enrollee-by-enrollee basis all advance CSR payments were correctly determined.

With respect to APTC payments, because CMS obtains APTC payment data from QHP issuers on only an aggregate basis, it is unable to verify the amounts requested through QHP issuers' attestations on an enrollee-by-enrollee basis. Unlike advance CSR payments, APTC amounts vary by enrollee. Thus, CMS cannot ensure that APTC payment amounts were appropriately

applied on behalf of confirmed enrollees. Further, CMS's lack of APTC payment data on an enrollee-by-enrollee basis affected our ability in this review to identify any potential overpayments and underpayments related to APTC payments at the individual level.

Without effective internal controls for ensuring that financial assistance payments are calculated and applied correctly, a significant amount (approximately $2.8 billion) of Federal funds are at risk (e.g., there is a risk that funds were authorized for payment to QHP issuers in the incorrect amounts). Our review focused on the effectiveness of CMS's internal controls and, for the aforementioned reasons, did not verify whether these Federal funds were accurately applied on behalf of confirmed enrollees on an enrollee-by-enrollee basis.

We note that CMS has the responsibility to verify that financial assistance payments made to QHP issuers are accurate. CMS also has the authority to (1) require QHP issuers to restate enrollment totals and payment amounts for prior months to reflect prior inaccurate payments and (2) recoup these payments by offsetting them against future payments or other means.[21] However, because CMS has not developed the systems to obtain enrollment and payment information on an enrollee-by-enrollee basis, CMS cannot verify the accuracy of the nearly $2.8 billion it authorized for financial assistance payments during our audit period. We plan to conduct an additional review that will address financial assistance payments on an enrollee-by-enrollee basis. The planned review will include the audit period covered by this review and collect information necessary to determine payment accuracy.

## CMS RELIED ON ISSUER ATTESTATIONS TO ENSURE THAT ADVANCE COST-SHARING PAYMENT RATES IDENTIFIED AS OUTLIERS WERE RELIABLE AND DID NOT USE QUALIFIED PERSONNEL TO REVIEW THESE OUTLIERS

The ACA directs a QHP issuer to notify CMS of CSRs made under the statute and directs CMS to make periodic and timely payments to the QHP issuer equal to the value of those CSRs.[22] The ACA permits advance payments of CSR amounts to QHP issuers on the basis of the amount specified by the Secretary.[23] An operation deficiency exists when personnel performing a control—in this instance, reviewing and approving actuarial support for index rates—are not qualified or properly skilled to perform the control effectively.[24]

For 2014, to calculate the advance CSRs, the marketplaces sent the applicable data from the QHP issuers to the Department. These data included the essential health benefit portion of the expected claim costs (called the "index rate" in this report). To determine the index rate, the

[21] *MOU Between IRS and CMS*; CMS control number MOU 13-150 (effective January 31, 2013); 45 CFR §§ 156.430(d) and (e).

[22] ACA § 1402(c)(3).

[23] ACA § 1412(c)(3).

[24] Office of Management and Budget (OMB) Circular A-123, *Management's Responsibility for Internal Control,* Appendix A, section II.D. OMB Circular A-123 defines a Federal agency's management responsibility for internal controls in that Federal agency.

issuer is required to submit to CMS complex actuarial calculations for all QHPs that an issuer offers in a State and a memorandum supporting those calculations.[25]

CMS did not independently review index rates it identified as outliers but relied on attestations from QHP issuers' financial officer or actuary that the index rates were accurate and consistent with the issuers' rate development practices. The index rates that issuers reported to CMS were the key factor in establishing advance CSR payment rates. The higher the index rate, the higher the advance CSR payment rate for all of a QHP's confirmed enrollees. To identify index rates that might have been excessive, CMS used a formula for identifying payment rate outliers developed by actuaries in its OACT. CMS defined outliers as index rates at or above the 90th percentile of index rates nationwide. Issuers with an index rate that CMS identified as an outlier were required to provide a financial officer's or actuary's attestation that the index rate was accurate and consistent with the issuer's rate development practices. After having received the attestation, CMS accepted the index rate as valid and calculated the advance CSR payment rate using the issuer's information.

CMS elected to have CCIIO—not OACT—be responsible for identifying and resolving potential outlier rates that were based on actuarial information. On the basis of CMS's written procedures for analyzing outlier index rates and discussions with CCIIO, we note that the personnel tasked with reviewing the rates did not have the skills needed to review index rate calculations or their actuarial support. Absent review by skilled staff, some of these rates may have resulted in inflated advance CSR payments. We note that OACT actuaries have the skills to review this documentation and could determine whether the identified outlier rates submitted by QHP issuers are appropriate.

## CMS DID NOT HAVE SYSTEMS IN PLACE TO ENSURE THAT FINANCIAL ASSISTANCE PAYMENTS WERE MADE ON BEHALF OF CONFIRMED ENROLLEES AND IN THE CORRECT AMOUNTS

The Federal and State marketplaces must transmit eligibility and enrollment information to the Department "promptly and without undue delay" (45 CFR §§ 155.340(a)(1) and (d)). According to two memoranda of understanding (MOUs) between CMS and IRS,[26] the marketplaces must transmit records identifying confirmed enrollees to CMS at the start of each monthly payment cycle. The Department needs this information so that it knows when to begin, modify, or end enrollee financial assistance payment processes for both APTC and CSR.

CMS did not have controls in place to ensure that financial assistance payments were made on behalf of only confirmed enrollees and in the correct amounts. During our audit period, CMS's electronic database for receiving and maintaining confirmed enrollee and payment information was being developed. As a result, CMS authorized financial assistance payments to QHP issuers

[25] An index rate is an issuer's average projected gross claims costs across all plans offered within an individual State.

[26] *MOU Between IRS and CMS*; CMS control numbers MOU 13-150 (effective January 31, 2013) and MOU 14-127, (effective January 17, 2014).

for enrollees associated with all 100 payee group-months in our sample but could not ensure that the financial assistance payments were properly applied to those enrollees.

While the electronic database was under development, CMS was using an interim process for calculating financial assistance payments. Under this interim process, CMS relied on QHP issuers to submit confirmed enrollee and payment information in the aggregate. Because issuers do not provide payment information on an enrollee-by-enrollee basis, CMS was unable to ensure that payments were applied correctly to individual enrollees.[27] CMS relied on issuers to attest that payments were applied to the appropriate enrollees. In addition, CMS required QHP issuers to restate enrollment totals and payment amounts for prior months through their monthly template submissions. Under the interim process, CMS is unable to verify that QHP issuers are properly adjusting enrollment totals and payment amounts on their templates to account for any improper financial assistance payments previously authorized by CMS.

For the 100 payee group-months included in our sample, CMS authorized financial assistance payments totaling $301,665,077 ($267,849,339 for APTCs and $33,815,738 for CSRs). On the basis of our sample results and our review of CMS's interim calculation process, we concluded that CMS did not verify that it correctly applied to confirmed enrollees any of the $2,767,169,143[28] in financial assistance payments that it made during the period January through April 2014. Without effective internal controls for ensuring that financial assistance payments are calculated and applied correctly, a significant amount of Federal funds are at risk.

## CMS DID NOT HAVE SYSTEMS IN PLACE FOR STATE MARKETPLACES TO SUBMIT ENROLLEE ELIGIBILITY DATA FOR FINANCIAL ASSISTANCE PAYMENTS

The marketplaces must transmit eligibility and enrollment information to the Department "promptly and without undue delay" so that the Department knows when to begin, modify, or end enrollee financial assistance payments" (45 CFR §§ 155.340(a)(1) and (d)). CMS did not have systems in place for State marketplaces to submit enrollee eligibility data for financial assistance payments. For 29 of the 100 sampled payee group-months, CMS did not verify the associated enrollees' eligibility for financial assistance payments.[29] This occurred because CMS did not maintain any confirmed enrollment and payment information data on enrollees who applied through State marketplaces, and State marketplaces were unable to share this information with CMS.[30] As of January 22, 2015, CMS was in the process of developing a computerized

[27] This affected our ability to identify financial assistance payments on an enrollee-by-enrollee basis and compare these amounts, when combined, to aggregate payments made to QHP issuers. If we had been able to do this, we could have ensured that aggregate payments were appropriately applied on behalf of eligible enrollees.

[28] This amount represents the known value of the sampling frame. Appendix E contains more detail on the sample results and estimates.

[29] The remaining 71 sampled payee group-months were associated with enrollees who applied through the CMS-administered Federal marketplace; therefore, CMS was able to verify their eligibility for financial assistance.

[30] This information is maintained by the agency charged with operating each State's marketplace.

system that State marketplaces could use to submit enrollee data. CMS maintains initial enrollment and payment information for QHP issuers in the Federal marketplace and can determine that at least the totals submitted by issuers on their templates do not exceed the maximum enrollment and payment threshold on the basis of initial enrollment. For State marketplaces, CMS must rely exclusively on issuers to attest to enrollee eligibility for financial assistance.

CMS made financial assistance payments totaling $26,713,614 ($22,399,969 for APTCs and $4,313,645 for CSRs) during the 29 sampled payee group-months associated with enrollees for whom CMS did not verify financial assistance eligibility. On the basis of our sample results, we estimated that CMS did not verify that $262,861,958 in financial assistance payments was authorized for eligible enrollees who applied through State marketplaces during the period January through April 2014.[31] Without effective internal controls that ensure that State marketplace enrollees are eligible for financial assistance, a significant amount of Federal funds are at risk.

## CMS DID NOT ALWAYS FOLLOW ITS GUIDANCE FOR CALCULATING ADVANCE COST-SHARING REDUCTION PAYMENTS AND DOES NOT PLAN TO PERFORM A TIMELY RECONCILIATION OF THESE PAYMENTS

The marketplaces must use the Department's methodology for calculating advance CSR payments and transmitting these amounts to the Department.[32] A CMS contractor prepared guidance for CMS to use in calculating advance CSR payments. This guidance states that advance CSR payments should be calculated by multiplying the per-member-per-month (PMPM) rate by the number of confirmed members.[33] As established in regulation, the Department will periodically reconcile the amount of advance CSR payments against the actual amount of CSR payments issuers made to QHP issuers on behalf of enrollees.[34]

### Incorrect Advance Cost-Sharing Reduction Payments

For 17 of the 100 sampled payee group-months, CMS did not follow its guidance for calculating advance CSR payments. We calculated that CMS authorized payments to issuers that were, in total, $314,485 less than what should have been paid for these group-months. The incorrect payments occurred for one of the following three reasons.

[31] The $262,861,958 is the point estimate and is not mutually exclusive of the estimation amount of $2,767,169,143 for verification of financial assistance payments appropriately applied. Appendix E contains more detail on the sample results and estimates.

[32] 45 CFR §155.1030(b)(3). The methodology, known as the Department's Notice of Benefit and Payment Parameters for 2014, is published in the Federal Register (78 Fed. Reg. 15410 (March 11, 2013)).

[33] The guidance, *Data Changes & Clean-ups Opera Made in Pre-Audit As of 4/19/14*, was prepared for CMS by the contractor (Opera Solutions, LLC) to assist CMS in correcting deficiencies in the data contained within the initial 834 transactions, which included the advance CSR payment amounts calculated for enrollees.

[34] 45 CFR § 156.430(d).

*Payment Was Within $2 of CMS's Approved Advance Cost-Sharing Reduction Payment Amount*

During 10 payee group-months, CMS's advance CSR payment calculation differed from what should have been paid because the value of the PMPM rate was within $2 of the plan's approved PMPM advance CSR amount—an arbitrary threshold set by CMS under its interim payment process. Under this process, CMS calculates an advance CSR for each issuer using the total CSR amount requested for all of the issuer's plans. CMS then validates the requested advance CSR amount by dividing the total amount requested for each plan by the number of confirmed enrollees reported to receive advance CSR payments in that plan. If that value is within $2 of the plan's approved PMPM advance CSR amount, CMS authorizes the total amount requested despite knowing that the amount differs from what it should actually authorize according to its own guidance. CMS stated that it allowed the variance in the plan's approved PMPM advance CSR amount because QHP issuers encountered "operational difficulties" when reporting accurate data. For the 10 payee group-months, we calculated that CMS authorized payments that were $34,742 more than they should have been.[35]

*CMS Based Payments on Amounts Requested by Issuers Instead of on Confirmed Enrollment*

Each month, QHP issuers submit a template to CMS that includes a variety of data, including the QHP's number of confirmed enrollees. This number is used in CMS's calculation of advance CSR payments. Contrary to CMS's own guidance, for four payee group-months we found that CMS did not calculate advance CSR payments using the number of confirmed enrollees reported on issuers' templates. Instead, CMS based payments on a separate column of the template where issuers reported the amount of advance CSR payments they were requesting.[36] Specifically:

- For two payee group-months, the issuers reported confirmed enrollment but did not request advance CSR payments in the separate column. Therefore, CMS did not make advance CSR payments to those issuers.

- For another two payee group-months, issuers requested and CMS paid more in advance CSR payments than the issuers' confirmed enrollment allowed them to receive.[37]

For these four payee group-months, CMS should have calculated the advance CSR payments using QHP issuer-provided confirmed enrollment data in accordance with CMS's own guidance. However, CMS authorized payments only if QHP issuers requested them—an accounting practice that resulted in CMS having to regularly reconcile QHP issuers' accounts, a process with potential for error. As previously stated, CMS deviated from its own contractor's

[35] We calculated total advance CSR payment amounts by multiplying the number of confirmed enrollees in each plan by that plan's approved PMPM advance CSR amount, per the guidance described in footnote 33 (*Data Changes & Clean-ups Opera Made in Pre-Audit As of 4/19/14*).

[36] The amount requested did not always equal the amount the issuer was allowed to receive per the guidance prepared by Opera Solutions, LLC.

[37] The issuers requested additional advance CSR payments to reconcile underpayments received in prior payee group-months.

guidance because QHP issuers encountered "operational difficulties" when reporting accurate data. In total, CMS authorized monthly payments that were $20,072 less than they should have been for these four payee group-months.

*CMS Made an "Operational Policy Decision" During 1 Month To Authorize Requested Advance Cost-Sharing Reduction Amounts, Regardless of the Amount*

For advance CSR payments requested for February 2014, CMS made what a high-level CMS official described as an "operational policy decision" to authorize all requested advance CSR payments because of the volume of templates received by CMS that exceeded the $2 PMPM threshold described above. (In practice, the decision was a management override of CMS's internal controls.) To address any February 2014 overpayments, CMS adjusted issuers' March 2014 payments, if appropriate. Three of our sampled payee group-months were affected by the operational policy decision. For these three payee group months, we calculated that CMS-authorized payments were $329,155 less than they should have been.[38]

On the basis of our sample results, we estimated that CMS incorrectly calculated advance CSR payments that were $3,094,529[39] less than they should have been for 167 payee group-months during the period January through April 2014.

**Timely Reconciliation of Advance Cost-Sharing Reduction Payments Not Performed**

In 2013, CMS stated that advance CSR payment amounts reimbursed to QHP issuers served as estimated payments and that all of these payments would be reconciled to actual CSR amounts that should have been paid to all plans for confirmed enrollees.[40] In addition, during our field work, CMS officials stated that this reconciliation would serve as CMS's primary control to address potentially inappropriate advance CSR payments. However, on February 13, 2015, CMS issued guidance stating that it will postpone until 2016 the reconciliation of advance CSR payments made for the 2014 benefit year.[41]

According to the CMS guidance, QHP issuers are having difficulty upgrading their systems and producing credible data to reconcile advance CSR payments to actual amounts. Due to the risk of QHP issuers providing inaccurate data to calculate actual CSR amounts, CMS stated that it has postponed reconciling advance CSR payments made to all QHP issuers for the 2014 benefit year until April 30, 2016. Without effective internal controls for ensuring that advance CSR payments are reconciled in a timely manner, a significant amount of Federal funds are at risk.

[38] Two of the three payee group-months were for March 2014, with total underpayments of $389,865. For the remaining payee group-month (February 2014), CMS authorized an overpayment of $60,710.

[39] This estimate is relatively imprecise; this imprecision is reflected in the associated 90-percent confidence interval, which ranges from -$8,127,641 to $1,938,583. The $3,094,529 is the point estimate. Appendix E contains more detail on the sample results and estimates.

[40] 78 Fed. Reg. 15541, 15544 (Mar. 11, 2013). Further, according to Federal regulations, CMS must perform periodic reconciliations of any advance CSRs provided to a QHP issuer (45 CFR § 156.430(d)).

[41] *Timing of Reconciliation of Cost-Sharing Reductions for the 2014 Benefit Year* (February 13, 2015).

## RECOMMENDATIONS

We recommend that CMS correct these internal control deficiencies by:

1. requiring OACT to review and validate QHP issuers' actuarial support for index rates used to calculate advance CSR payment rates that CMS identifies as outliers,

2. implementing computerized systems to maintain confirmed enrollee and payment information so that it does not have to rely on QHP issuers' attestations in calculating payments,

3. implementing a computerized system so State marketplaces can submit enrollee eligibility data,

4. following its guidance for calculating estimated advance CSR payments, and

5. developing interim reconciliation procedures to address potentially inappropriate CSR payments.

## CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

### CMS COMMENTS

In written comments on our draft report, CMS concurred with our second, third, and fifth recommendations. CMS generally agreed with our first and fourth recommendations but indicated that the recommendations are no longer applicable because of regulatory action.

CMS stated that it was pleased to note that we did not report any deficiencies in our review of APTCs included in our sample of 100 payee group-months. CMS also stated that our findings related to advance CSR payments represented 0.1 percent of the total payments included in our sample. In addition, CMS acknowledged that it has not established a computerized payment system; however, it is currently testing a pilot program that will enable CMS to obtain individual enrollment data. Nevertheless, even when this system is fully implemented, CMS stated that QHP issuers will continue to be its source for confirming enrollment data. CMS also stated that it conducted an internal controls review over its financial reporting that determined its processes to be effective. In addition, an independent accounting firm conducted a similar review and reported no significant issues.

Regarding our first recommendation (requiring OACT to review and validate QHP issuers' actuarial support for index rates identified as outliers), CMS stated that it took regulatory action that eliminated the use of index rates in calculating advance CSR payment rates. As such, CMS stated that OACT will not need to review CMS's modified methodology for calculating these rates. CMS indicated that its regulatory action also affected our fourth recommendation—that CMS follow its own guidance for calculating estimated advance CSR payments. Specifically, CMS stated that for the 2015 benefit year, marketplaces now calculate the advance CSR payment

amount for a specific policy as the product of the total monthly premium for that policy and a CSR plan "variation multiplier." CMS also stated that we based our findings related to advance CSR payments on an "alternative interpretation" of CMS guidance that produced a "point-in-time payment amount" that did not reflect corrections to past underpayments or overpayments. Finally, CMS stated that to address OIG concerns, by April 2015 it would eliminate its $2 PMPM threshold for when it requests advance CSR amounts from QHP issuers.

CMS's comments are included in their entirety as Appendix F.

## OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing CMS's comments, we maintain that our findings and recommendations are valid. CMS's regulatory actions may appropriately address the findings related to our first and fourth recommendations. However, we have not tested the new advance CSR payment calculation described in the regulation. Therefore, we cannot determine whether the new calculation methodology allows for the type of discrepancies we identified during our audit period.

We disagree with CMS's statement that we did not report any deficiencies in our review of APTCs included in our sample of 100 payee group-months. As we noted in the report, CMS does not maintain enrollment data on an enrollee-by-enrollee basis. (QHP issuers' templates did not identify the confirmed enrollees in their plans.) This affected our ability to identify any potential deficiencies with APTC payments, as these amounts vary by enrollee. If CMS maintained adequate APTC data for specific enrollees, we could have tested the appropriateness of aggregate payments made on their behalf. Regarding the independent accounting firm's review of CMS's financial reporting, we note that the accounting firm's review tested for basic transactions and security vulnerabilities. Further, the accounting firm reported findings related to advance CSR payments similar to those in this report.[42]

We also disagree with CMS's statement that our findings related to advance CSR payments represented 0.1 percent of the total payments included in our sample. A sample payee-group month included both aggregate APTC and advance CSR payments; therefore, it would not be appropriate to associate the approximately $314,000 in advance CSR payments identified in our report as an underpayment with all of the payments included in our sample. We used CMS's calculation methodology described in its own guidance to identify the advance CSR underpayments. In addition, we reviewed restatements of prior months when they were included in our sample payee-group month. However, because CMS did not have systems in place to ensure that financial assistance payments were made on behalf of confirmed enrollees and in the correct amounts or for State marketplaces to submit enrollee eligibility data for financial assistance payments, we could not verify that CMS correctly applied any of the nearly $2.8 billion in financial assistance payments that it made during the period January through April 2014.

[42] CMS did not provide us with a copy of its internal controls review. Therefore, we cannot comment on that report.

## APPENDIX A: GLOSSARY OF SELECTED TERMS

This glossary is not intended to be a comprehensive source of technical or regulatory definitions. Rather, it provides basic definitions for a general understanding of selected terms used in this report.

**834 transactions:** Electronic files used to share health insurance information between QHP issuers, marketplaces, and CMS. These files are also commonly used by employers, unions, and government plan sponsors (e.g., Medicare Part D) to enroll members in a health insurance plan, the standards of which are set by the Health Insurance Portability and Accountability Act. An initial 834 transaction contains the calculation for any applicable financial assistance amounts that would be sent from the marketplace to the selected QHP issuer. A confirmation 834 transaction is created after the QHP issuer reviews the data in the application and ensures that enrollees paid their portion of the first month's premium (premium amount less APTC) in order to receive any financial assistance payments.

**attestation agreements:** For purposes of this report, the act of the signing of a document verifying that all information provided is accurate and in compliance with Federal policies and regulations.

**confidence interval:** Consists of a range of values (interval) that act as good estimates of the unknown population parameter. The level of confidence of the confidence interval would indicate the probability that the confidence range captures this true population parameter given a distribution of samples.

**confirmed enrollees:** Individuals enrolled in a QHP who have paid their first month's premium and have had their enrollment information approved by the QHP issuer.

**funds at risk**: Risk that material errors could occur in an account balance or class of transactions that will not be prevented or detected on a timely basis by the system of internal accounting controls.

**index rate:** For purposes of this report, the estimated amount a QHP issuer expects to pay for allowed claims for essential health benefits to enrollees for all of the QHP issuer's plans offered in a State.

**internal controls:** Processes in place to prevent or detect any possible substantial errors. According to the Government Accountability Office's *Standards for Internal Control in the Federal Government*, internal controls are processes effected by an entity's oversight body, management, and other personnel that provide reasonable assurance that the objectives of an entity will be achieved. These objectives and related risks can be broadly classified into one or more of the following three categories: operations (effectiveness and efficiency of operations), reporting (reliability of reporting for internal and external use), and compliance (compliance with applicable laws and regulations).

**internal control deficiencies:** Deficiencies in internal controls exist when the design or operation of a control does not allow management or employees to prevent or detect substantial errors in a timely manner. Materiality of the control deficiency is not just determined by the actual misstatement (i.e., dollar amount of the error) but by the potential dollar amounts that could also be incorrect.

**marketplace:** A health insurance exchange designed to serve as a "one-stop shop" where individuals can obtain information about health insurance options, determine eligibility for QHPs and insurance affordability programs, and select the plan of their choice.

**metal-level:** Health insurance plans in each "metal-level" pay different amounts of the total costs of an average person's care, which take into account the plans' monthly premiums, deductibles, copayments, coinsurance, and out-of-pocket maximums. Metal-levels are categorized as bronze, silver, gold, and platinum.

**operation deficiency:** Exists when personnel performing a control are not qualified or properly skilled to perform the control effectively.

**outlier:** A value that diverges greatly (i.e., much smaller or larger) from most of the other values in a data set.

**point estimate:** For statistical purposes, involves the use of sample data to calculate a single value that serves as an estimate of an unknown (fixed or random) population parameter.

**premium:** The monthly amount due QHP issuers for an individual policyholder to receive health coverage.

**qualified personnel:** Individuals with characteristics or abilities gained through training, experience, or both, as measured against the established requirements for a particular industry.

**utilization factor:** For purposes of this report, adjusts cost-sharing amounts to account for greater utilization of health care services induced by lower enrollee cost sharing in higher metal level plans.

## APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL WORK

The OIG *Work Plan* for fiscal year 2015 summarizes new and ongoing reviews and activities, including Affordable Care Act reviews, that OIG plans to pursue with respect to HHS programs and operations during the current fiscal year and beyond. In addition, OIG has issued several reports on marketplace issues related to the Affordable Care Act. (See below.)

| Report Title | Report Number | Date Issued |
|---|---|---|
| *California Implemented Security Controls Over the Web Site and Databases for Its Health Insurance Exchange but Could Improve Protection of Personally Identifiable Information* | A-09-14-03005 | 04/30/2015 |
| *Early Alert: Without Clearer Guidance, Marketplaces Might Use Federal Funding Assistance for Operational Costs When Prohibited by Law* | A-01-14-02509 | 04/27/2015 |
| *Review of the Accounting Structure Used for the Administration of Premium Tax Credits* | OEI-06-14-00590 | 3/31/2015 |
| *Maryland Misallocated Millions to Establishment Grants for a Health Insurance Marketplace* | A-01-14-02503 | 3/26/2015 |
| *Federal Marketplace: Inadequacies in Contract Planning and Procurement* | OEI-03-14-00230 | 01/20/2015 |
| *Health Insurance Marketplaces Generally Protected Personally Identifiable Information but Could Improve Certain Information Security Controls* | A-18-14-30011 | 09/22/2014 |
| *An Overview of 60 Contracts That Contributed to the Development and Operation of the Federal Marketplace* | OEI-03-14-00231 | 08/26/2014 |
| *Marketplaces Faced Early Challenges Resolving Inconsistencies With Applicant Data* | OEI-01-14-00180 | 07/02/2014 |
| *Not All Internal Controls Implemented by the Federal, California, and Connecticut Marketplaces Were Effective in Ensuring That Individuals Were Enrolled in Qualified Health Plans According to Federal Requirements* | A-09-14-01000 | 06/30/2014 |
| *Observations Noted During the OIG Review of CMS's Implementation of the Health Insurance Exchange—Data Services Hub* | A-18-13-30070 | 08/02/2013 |

## APPENDIX C: AUDIT SCOPE AND METHODOLOGY

### SCOPE

Our review covered financial assistance payments made for 984 payee group-months, totaling $2,767,169,143, for which CMS reimbursed QHP issuers during the period January through April 2014. A payee group-month is defined as all financial assistance payments made for a group of QHP issuers under one TIN for 1 month.

The scope of our audit did not require us to review enrollee eligibility or calculate actual financial assistance payments claimed for reimbursement. Rather, we limited our review to CMS's internal controls for determining financial assistance amounts and processing payments to QHP issuers.

We performed our fieldwork at CMS's central office in Baltimore, Maryland, and at the OIG Office of Audit Services New York regional office from April through December 2014.

### METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal requirements;
- met with CMS officials from CCIIO, OFM, and OACT to gain an understanding of their processes for administering and approving financial assistance payments, determining financial assistance amounts, and authorizing payments to QHP issuers;
- obtained the final master vendor management file for January through April 2014 to identify all QHP issuers approved to receive financial assistance payments;
- obtained from CMS's HIGLAS a sampling frame of 984 payee group-months for payments, totaling $2,767,169,143, for which CMS authorized reimbursement to QHP issuers for financial assistance payments for the period January through April 2014;
- selected a simple random sample of 100 payee group-months from the sampling frame and, for each payee group:
    - reviewed advance CSR payment rate information provided by issuers used in their calculations for payment,
    - verified that the QHP issuers that made up the payee group were certified to receive financial assistance payments, and
    - attempted to verify that calculated financial assistance amounts were accurate;

- estimated (1) the total amount of financial assistance payments that CMS was unable to verify and (2) the total amount and number of advance CSR payments that CMS incorrectly calculated in our sampling frame of 984 payee group-months; and

- discussed the results of our review with CMS officials.

Appendix D contains our statistical sampling methodology and Appendix E contains our sample results and estimates.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

## APPENDIX D: STATISTICAL SAMPLING METHODOLOGY

### POPULATION

The population consisted of all payee group-months for financial assistance payments made to QHP issuers submitted to CMS for reimbursement during the period January through April 2014. A payee group-month is defined as all financial assistance payments made for a group of QHP issuers under one TIN for 1 month.

### SAMPLING FRAME

The sampling frame was an Excel file containing 984 payee group-months with payments totaling $2,767,169,143 for which CMS reimbursed QHP issuers for financial assistance payments during the period January through April 2014. The data for payee group-month payments were provided by CCIIO's HIGLAS.

### SAMPLE UNIT

The sample unit was a payee group-month.

### SAMPLE DESIGN

We used a simple random sample.

### SAMPLE SIZE

We selected a sample of 100 payee group-months.

### SOURCE OF THE RANDOM NUMBERS

We generated the random numbers with the OIG Office of Audit Services statistical software.

### METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the payee group-months in our sampling frame. After generating 100 random numbers, we selected the corresponding frame items for our sample.

### ESTIMATION METHODOLOGY

We used the OIG Office of Audit Services statistical software to calculate our estimates. We estimated the total amount of financial assistance payments that CMS was (1) unable to verify were appropriately applied on behalf of confirmed enrollees and (2) unable to verify were made for eligible enrollees who applied through State marketplaces. We also estimated the total amount and number of advance CSR payments that CMS incorrectly calculated. The confidence intervals for the reported point estimates can be found in Appendix E.

## APPENDIX E: SAMPLE RESULTS AND ESTIMATES

### CMS DID NOT HAVE SYSTEMS IN PLACE TO ENSURE THAT FINANCIAL ASSISTANCE PAYMENTS WERE MADE ON BEHALF OF CONFIRMED ENROLLEES AND IN THE CORRECT AMOUNTS

**Table 2: Sample Details and Results**

| Payee Group-Months in Frame | Value of Frame | Sample Size | Value of Sample | Payee Group-Months With Payments Not Verified To Be Appropriately Applied | Value of Payments Not Verified To Be Appropriately Applied |
|---|---|---|---|---|---|
| 984 | $2,767,169,143 | 100 | $301,665,077 | 100 | $301,665,077 |

**Table 3: Estimated Value of Financial Assistance Payments Not Verified To Be Appropriately Applied**
***(Limits Calculated for a 90-Percent Confidence Interval)***

| | |
|---|---|
| Point estimate | $2,767,169,143[43] |
| Lower limit | 1,902,548,635 |
| Upper limit | 2,767,169,143[43] |

### CMS DID NOT HAVE SYSTEMS IN PLACE FOR STATE MARKETPLACES TO SUBMIT ENROLLEE ELIGIBILITY DATA FOR FINANCIAL ASSISTANCE PAYMENTS

**Table 4: Sample Details and Results**

| Payee Group-Months in Frame | Value of Frame | Sample Size | Value of Sample | Payee Group-Months With State Marketplace Payments for Which Enrollee Eligibility Was Not Verified | Value of State Marketplace Payments for Which Enrollee Eligibility Was Not Verified |
|---|---|---|---|---|---|
| 984 | $2,767,169,143 | 100 | $301,665,077 | 29 | $26,713,614 |

[43] The point estimate and upper limit calculated using the OIG Office of Audit Services statistical software were $2,968,384,362 and $4,034,220,088, respectively. The estimates were adjusted downward based on the known value of the sampling frame.

**Table 5: Estimated Value of State Marketplace Payments for Which Enrollee Eligibility Was Not Verified**
***(Limits Calculated for a 90-Percent Confidence Interval)***

| | |
|---|---|
| Point estimate | $262,861,958 |
| Lower limit | 103,644,991 |
| Upper limit | 422,078,925 |

## CMS DID NOT ALWAYS FOLLOW ITS GUIDANCE FOR CALCULATING ADVANCE COST-SHARING REDUCTION PAYMENTS

**Table 6: Sample Details and Results**

| Payee Group-Months in Frame | Value of Frame | Sample Size | Value of Sample | Payee Group-Months With Incorrect Advance Cost-Sharing Reduction Payments | Value of Incorrect Advance Cost-Sharing Reduction Payments |
|---|---|---|---|---|---|
| 984 | $2,767,169,143 | 100 | $301,665,077 | 17 | ($314,485) |

**Table 7: Estimated Number of Payee Group-Months and Value of Incorrect Advance Cost-Sharing Reduction Payments**
***(Limits Calculated for a 90-Percent Confidence Interval)***

| | Payee Group-Months With Incorrect Advance Cost-Sharing Reduction Payments | Value of Incorrect Advance Cost-Sharing Reduction Payments |
|---|---|---|
| Point estimate | 167 | ($3,094,529) |
| Lower limit | 113 | (8,127,641) |
| Upper limit | 236 | 1,938,583 |

## APPENDIX F: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*
Washington, DC 20201

**DATE:** MAR 17 2015

**TO:** Daniel R. Levinson, Inspector General
Office of the Inspector General

**FROM:** Andrew M. Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services

**SUBJECT:** OIG Draft Report "CMS's Internal Controls Did Not Effectively Ensure the Accuracy of Aggregate Financial Assistance Payments Made to Qualified Health Plan Issuers Under the Affordable Care Act" (A-02-14-02006)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review the Office of the Inspector General's (OIG) draft report on advance payment of the premium tax credits (APTC) and Cost-Sharing Reductions (CSR). CMS has continuously worked to implement a rigorous and effective set of internal controls over the interim manual payment process. CMS is addressing or has already addressed all of the OIG's recommendations in this report. CMS is also pleased to note the majority of the CSR underpayments identified in this report are a result of policies that CMS has already revised or changed. CMS is also pleased to note that, while the OIG reviewed a random sample of 100 monthly payments for APTC and CSR from CMS to qualified health plan (QHP) issuers, the OIG did not have any findings related to APTCs.

Each month, CMS receives completed templates from issuers and certain State Based Marketplaces (SBMs) on behalf of its issuers to calculate the payment amounts owed to issuers for Marketplace financial assistance on behalf of eligible enrollees. Once a month, issuers restate/update their prior month enrollment counts for a number of events including retroactive enrollments, terminations, special enrollment periods, and grace periods. This payment process is designed to account for fluctuations in issuer data that are the result of normal business processes, while protecting taxpayer dollars by reconciling issuer data on an ongoing basis. This restatement/update process is similar to that of other programs including Medicare Advantage and Part D.

CMS takes the stewardship of tax dollars seriously and implemented a series of payment and process controls to assist in making manual financial assistance payments accurately to issuers. These controls include parallel processing and multiple levels of review of the data at CMS, and requiring QHP issuers to certify the accuracy of their data submissions each month as a prerequisite for payment. A deliberate misstatement of data in the face of this certification would

constitute fraud. In addition, under CMS's Office of Management and Budget A-123 internal controls review over financial reporting, key controls surrounding this payment process were tested and determined to be operating effectively. Moreover, an independent certified public accounting firm conducted its review of the payment process and reported no significant issues. Both reviews were completed with no significant deficiencies or material weaknesses identified over the payment process. While CMS lacks fully automated payment systems, it has implemented a rigorous and effective set of internal controls to make accurate payments.

Issuers are the source of information on who has paid their premiums, which is the criterion for enrollment effectuation. Issuers will continue providing data on effectuated enrollment to CMS even after a fully automated payment process has been implemented. CMS is working to implement a process to receive effectuated enrollment information through the Federally Facilitated Marketplace (FFM) and is currently pilot testing this process with issuers. CMS continues this process as part of its work toward making APTC and CSR payments to issuers based on policy-level (individual) enrollment data. In addition, CMS continues to conduct internal validation checks for payment accuracy with policy level enrollment data from issuers.

Finally, OIG identified approximately $314,000 as a reported underpayment. This finding represents approximately 0.1 percent of the sample of approximately $301 million in total payments. The majority of CSR underpayments identified in the report are a result of an alternate interpretation of CMS's guidance by the OIG of the calculation methodology, which does not take into account restatements of the monthly payment amounts.

**OIG Recommendation**

We recommend that CMS correct internal control deficiencies by requiring the Office of the Actuary (OACT) to review and validate QHP issuers' actuarial support for index rates that CMS identifies as outliers.

**CMS Response**

We note that the recommendation is not applicable to 2015 or future years as the CSR rate calculation formula has been changed by regulation. For the 2015 benefit year, CMS modified the methodology for calculating cost-sharing reduction advance payment rates. Marketplaces will use a methodology for calculating the advance payment amounts that will not require QHP issuers to submit an estimate of the value of cost-sharing reductions to be provided for the EHB portion of expected allowed claims costs. Instead, Marketplaces will calculate the monthly advance payment amount for a specific policy as the product of the total monthly premium for the specific policy and a cost-sharing reduction plan variation multiplier. Because this process no longer involves reliance on index rates, this review does not occur, and OACT will not need to review.

**OIG Recommendation**

We recommend that CMS correct internal control deficiencies by implementing computerized systems to maintain confirmed enrollee and payment information so that CMS does not have to rely on QHP issuers' attestations in calculating payments.

**CMS Response**

CMS concurs with this recommendation. Issuers are the source of information on who has paid their premiums, which is the criterion for enrollment effectuation. Issuers will continue providing data on effectuated enrollment to CMS even after an automated payment process has been fully implemented. CMS is working to implement a process to receive effectuated enrollment information through the FFM and is currently pilot testing this process with issuers. CMS continues this process as part of its work toward making APTC and CSR payments to issuers based on policy-level (individual) enrollment data. In addition, CMS continues to conduct internal validation checks for payment accuracy with policy level enrollment data from issuers.

**OIG Recommendation**
We recommend that CMS correct internal control deficiencies by implementing a computerized system so State marketplaces can submit enrollee eligibility data.

**CMS Response**
CMS concurs with this recommendation. CMS is working to implement an automated process to receive effectuated enrollment information from State Based Marketplaces.

**OIG Recommendation**
We recommend that CMS correct internal control deficiencies by following its guidance for calculating estimated advance CSR payments.

**CMS Response**
We note that the recommendation is not applicable to 2015 or future years, as the CSR rate calculation formula has been changed by regulation. In 2015, CMS used a different method to calculate the advance CSR payments to issuers. Marketplaces now calculate the monthly advance payment amount for a specific policy as the product of the total monthly premium for the specific policy, and a cost-sharing reduction plan variation multiplier.

In addition, the OIG based their findings on an alternative interpretation of CMS's guidance. In some cases the OIG's method produces a point-in-time payment amount that does not reflect corrections to past underpayments or overpayments. In other cases, it leads to a different payment amount due to the $2 per member per month (PMPM) variance we allowed. CMS allowed a slight variance in the CSR PMPM rate to account for the effects of operational difficulties faced by many issuers and SBMs in receiving accurate CSR data. To address the OIG concern, this $2 PMPM allowance will be completely eliminated and payment adjustments made accordingly for all 2014 payment months in the April 2015 payment cycle. As stated above, there is a new process in place for advance CSR payment for 2015.

**OIG Recommendation**
We recommend that CMS correct internal control deficiencies by developing interim reconciliation procedures to address potentially inappropriate CSR payments.

**CMS Response**
CMS concurs with this recommendation. In order for CMS to enhance the accuracy of reconciliation of CSR payments to issuers, and to fully reimburse issuers for reductions in out-of-pocket expenses provided to eligible low- and moderate-income enrollees, and American

Indian/Alaska Native enrollees in 2014, CMS will reconcile 2014 benefit year cost-sharing reductions for all issuers in April 2016.

CMS permitted issuers that selected the simplified methodology for calculating CSR payments to switch to the more accurate standard methodology[1], and will reconcile 2014 benefit year cost-sharing reductions for all issuers beginning on April 30, 2016. This new reconciliation deadline for all issuers will promote accurate reimbursement of cost-sharing reductions by permitting issuers that switch to, or previously selected, the more accurate standard methodology to complete their operational upgrades.

CMS continues to provide technical assistance to issuers and, in advance of pilot testing for 2016 cost-sharing reduction reconciliation data submission for benefit years 2014 and 2015, CMS will provide technical data submission standards and appropriate instruction.

CMS thanks OIG for their efforts on this issue and looks forward to working with OIG on this and other issues in the future.

[1] Advanced payments of cost-sharing reductions are reconciled by comparing the cost sharing that an enrollee pays under a cost-sharing reduction plan variation of the QHP to the cost sharing the enrollee would have paid under the standard plan. The cost sharing that would have been paid under the standard plan is most accurately calculated by adjudicating an enrollee's claims history for the year through the standard plan cost-sharing parameters, a process sometimes referred to as "double adjudication," and referred to under CMS regulations as the "standard methodology."

Under CMS regulations, as a transitional measure, issuers were permitted to elect either to calculate cost sharing that an enrollee would have paid under the standard plan using the standard methodology – the most accurate approach – or to estimate that cost sharing using a simplified methodology based on actuarial estimates of certain key cost-sharing parameters.

On February 13, 2015, CMS announced that issuers that previously elected to use the simplified methodology may choose to switch to the more accurate standard methodology and that CMS will reconcile 2014 benefit year CSRs for all issuers beginning on April 30, 2016.

National Health Interview Survey
Early Release Program

# Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, 2014

by Robin A. Cohen, Ph.D., and Michael E. Martinez, M.P.H., M.H.S.A.
Division of Health Interview Statistics, National Center for Health Statistics

## Highlights

- In 2014, 36.0 million persons of all ages (11.5%) were uninsured at the time of interview, 51.6 million (16.5%) had been uninsured for at least part of the year prior to interview, and 26.3 million (8.4%) had been uninsured for more than a year at the time of interview.
- Among persons under age 65, 63.6% (170.4 million) were covered by private health insurance plans at the time of interview. This includes 2.2% (5.9 million) covered by private plans through the Health Insurance Marketplace or state-based exchanges at the time of interview between January and December 2014. The proportion with exchange coverage increased from 1.4% (3.7 million) in the first quarter of 2014 (January–March) to 2.5% (6.7 million) in the fourth quarter of 2014 (October–December).
- Among adults aged 18–64, the percentage who were uninsured at the time of interview decreased from 20.4% in 2013 to 16.3% in 2014.
- Among adults aged 19–25, the percentage who were uninsured at the time of interview decreased from 26.5% in 2013 to 20.0% in 2014.
- In 2014, the percentage of persons under age 65 who were uninsured at the time of interview varied by state. For example, 2.5% were uninsured in Hawaii, whereas 21.5% were uninsured in Oklahoma and Texas.

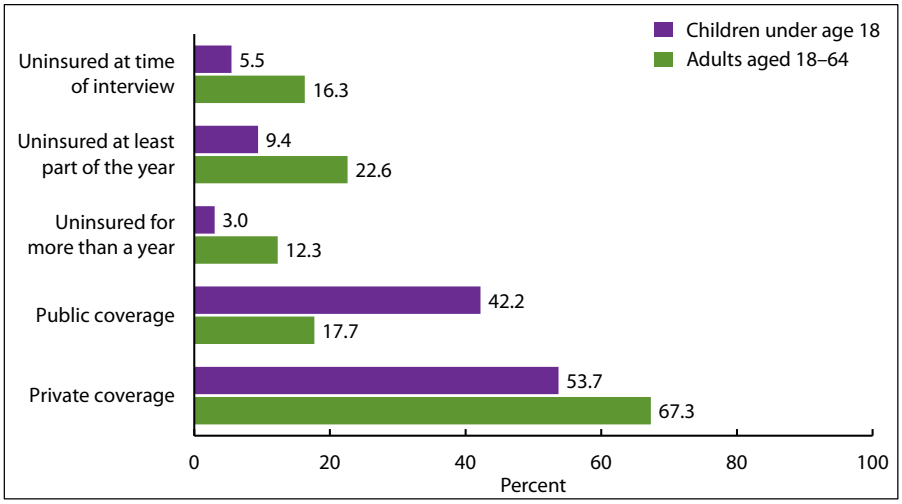
## Introduction

The Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics (NCHS) is releasing selected estimates of health insurance coverage for the civilian noninstitutionalized U.S. population based on data from the 2014 National Health Interview Survey (NHIS), along with comparable estimates from the 2009–2013 NHIS. Estimates for 2014 are based on data for 111,682 persons.

Three estimates of lack of health insurance coverage are provided: (a) uninsured at the time of interview, (b) uninsured at least part of the year prior to interview (which includes persons uninsured for more than a year), and (c) uninsured for more than a year at the time of interview (Tables 1 and 2). Estimates of public and private coverage are also presented (Table 3). Table 3 also includes estimates for 1997 and 2005.

Additional tables present estimates of uninsurance, public coverage, and private coverage by poverty status for persons under age 65 (Table 4), adults aged 18–64 (Table 5), and children aged 0–17 (Table 6). Table 7 shows the percentages of persons who were uninsured, had public coverage, and had private coverage, by age and sex. Estimates for persons under age 65, by race and ethnicity, are shown in Table 8. Table 9 presents estimates for adults aged 18–64 by other selected demographic characteristics that are relevant to adults only.

**Figure 1. Percentage of persons without health insurance, by age group using three measures of noncoverage, and percentage of persons with health insurance at time of interview, by coverage type and age group: United States, 2014**




NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
DATA SOURCE: CDC/NCHS, National Health Interview Survey, 2014, Family Core component.

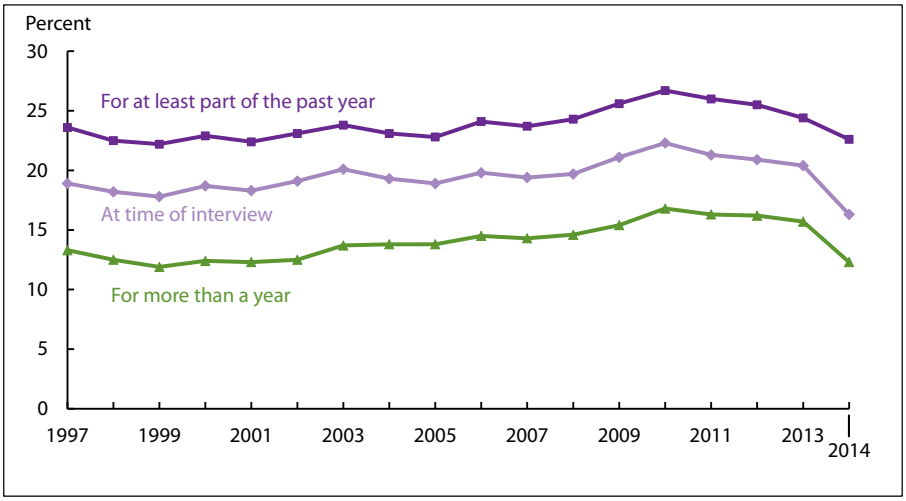
For individuals with private health insurance, estimates are presented in Tables 10 and 11 for enrollment in high-deductible health plans (HDHPs), enrollment in consumer-directed health plans (CDHPs), and being in a family with a flexible spending account (FSA) for medical expenses.

This report includes four tables that address regional and state differences. Tables 12 and 13 present estimates of uninsurance, public coverage, and private coverage by each state's Affordable Care Act (ACA) of 2010 (P.L. 111–148, P.L. 111–152) implementation characteristics. Specifically, Table 12 presents estimates by state Medicaid expansion status as of October 31, 2013. Table 13 shows estimates by state Health Insurance Marketplace type. Expanded regional and state-level estimates of uninsurance at the time of interview, and public and private coverage, are presented in Tables 14 and 15. State-specific health insurance estimates are presented for all 50 states and the District of Columbia for persons of all ages, persons under age 65, and adults aged 18–64; and for 40 states for children aged 0–17.

Most of the tables in this report provide estimates prior to and after implementation of the Health Insurance Marketplaces and Medicaid expansion provisions that began in January 2014. The 2014 estimates after implementation are based on a full year of data collected from January through December 2014 and, therefore, are centered around the midpoint of this period.

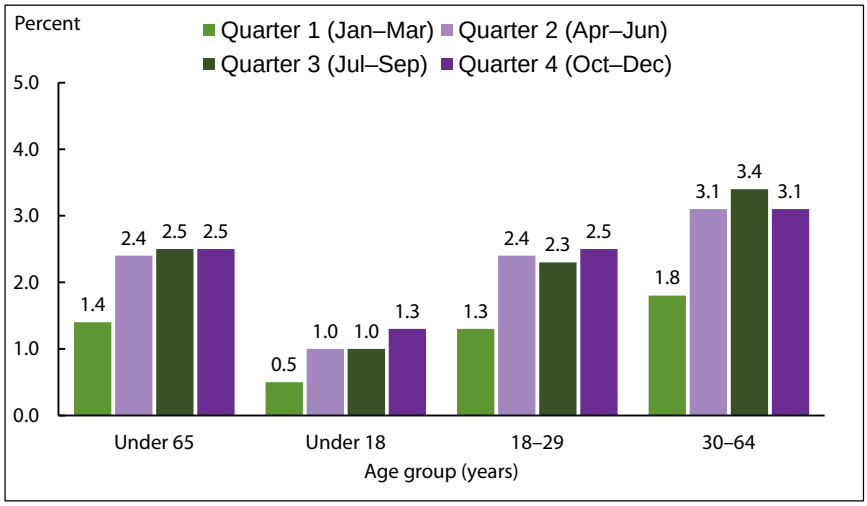
This report is updated quarterly and is part of the NHIS Early Release (ER) Program, which releases updated selected estimates that are available from the NHIS website at: http://www.cdc.gov/nchs/nhis.htm. Estimates for each calendar quarter, by selected demographics, are also available as a separate set of tables through the ER program. For more information about NHIS and the ER Program, see the Technical Notes and the Additional Early Release Program Products sections at the end of this report.

**Figure 2. Percentages of adults aged 18–64 who lacked health insurance coverage at time of interview, for at least part of the past year, or for more than a year: United States, 1997–2014**




NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
DATA SOURCE: CDC/NCHS, National Health Interview Survey, 1997–2014, Family Core component.

**Figure 3. Percentage of persons under age 65 with private health insurance obtained through the Health Insurance Marketplace or state-based exchanges, by age group and quarter: United States, 2014**




NOTES: Data include persons who have purchased a private health insurance plan through the Health Insurance Marketplace or state-based exchanges that were established as part of the Affordable Care Act of 2010 (P.L. 111–148, P.L. 111–152). All persons who have exchange-based coverage are considered to have private health insurance. Data are based on household interviews of a sample of the civilian noninstitutionalized population.
DATA SOURCE: CDC/NCHS, National Health Interview Survey, 2014, Family Core component.

# Results

## Lack of health insurance coverage

In 2014, the percentage of persons uninsured at the time of interview was 11.5% (36.0 million) for persons of all ages, 13.3% (35.7 million) for persons under age 65, 5.5% (4.0 million) for children aged 0–17, 16.3% (31.7 million) for adults aged 18–64, and 20.0% (6.0 million) for adults aged 19–25 (Tables 1 and 2). Adults aged 18–64 were almost three times as likely as children to be uninsured at the time of interview (Table 1 and Figure 1).

The percentage of persons uninsured for at least part of the year was 16.5% (51.6 million) for persons of all ages, based on data from 2014 (Tables 1 and 2). Among persons under age 65, 19.0% (50.8 million) were uninsured for at least part of the year. Adults aged 18–64 were more than twice as likely (22.6%) as children (9.4%) to experience this lack of coverage (Table 1 and Figure 1). Among adults aged 19–25, 26.9% had

been uninsured for at least part of the past year.

Regarding persistent lack of coverage, 8.4% (26.3 million) of persons of all ages had been uninsured for more than a year (Tables 1 and 2). Among persons under age 65, 9.7% (26.1 million) had been uninsured for more than a year. Adults aged 18–64 were more than four times as likely (12.3%) as children (3.0%) to have been uninsured for more than a year (Table 1 and Figure 1). Among adults aged 19–25, the percentage uninsured for more than a year was 14.2% (Table 1).

From 2013 to 2014, significant decreases were noted in the percentages of persons who were uninsured at the time of interview among persons of all ages, those under age 65, those aged 18–64, those aged 19–25 and children aged 0–17. The largest decrease was for adults aged 19–25, from 26.5% in 2013 to 20.0% in 2014.

For all age groups except children, significant decreases were seen in the percentages of persons who were uninsured at least part of the year prior to interview between 2013 and 2014. The largest decrease was for adults aged 19–25, from 31.3% in 2013 to 26.9% in 2014.

For all age groups, decreases were noted from 2013 to 2014 in the percentage of persons who had been uninsured for more than a year. For this measure of persistent lack of coverage, the largest decrease was for adults aged 19–25, from 19.8% in 2013 to 14.2% in 2014.

The percentages of adults aged 18–64 who were uninsured at the time of interview, who lacked coverage for at least part of the past year, and who had been uninsured for more than a year had generally increased from 1997 to 2010, but decreased from 2010 to 2014 (Figure 2).

Among children aged 0–17, the percentage who were uninsured at the time of interview has generally decreased, from 13.9% in 1997 to 5.5% in 2014 (Table 3).

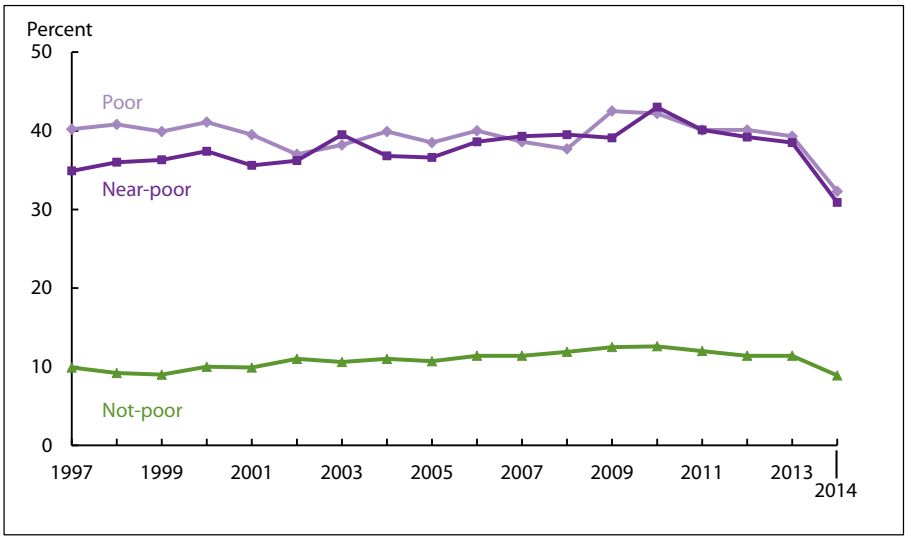
## Public and private coverage

In 2014, 24.5% of persons under age 65 were covered by public health plans at the time of interview (Table 3). More than two-fifths of children were covered by a public plan (42.2%), compared with 17.7% of adults aged 18–64 (Table 3 and Figure 1). Public coverage among adults aged 18–64 increased from 16.7% in 2013 to 17.7% in 2014. Public coverage among adults aged 19–25 was 19.1% in 2014 (Table 3), a significant increase from 2013 (16.1%). Between 2013 and 2014, no significant changes were seen in the percentage of persons with public coverage among persons of all ages, those under 65, and children aged 0–17.

Among adults aged 18–64, public coverage increased between 1997 (10.2%) and 2014 (17.7%) (Table 3). Among children, the percentage with public coverage almost doubled between 1997 (21.4%) and 2014 (42.2%).

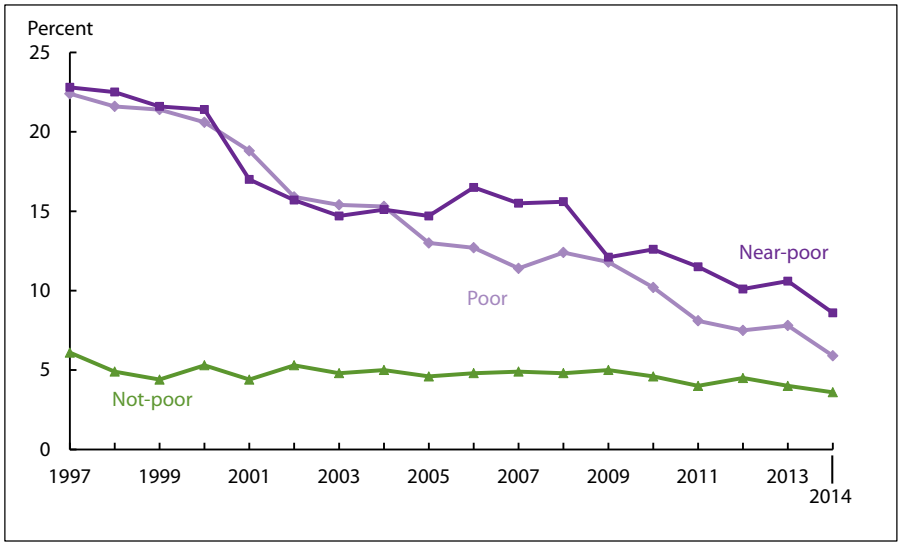
Among persons under age 65, 63.6% (170.4 million) were covered by private health insurance plans at the time of interview in 2014 (Table 3). This includes 2.2% (5.9 million) covered by private plans obtained through the Health Insurance Marketplace or state-based exchanges. A significant increase

**Figure 4. Percentage of adults aged 18–64 who were uninsured at the time of interview, by poverty status: United States, 1997–2014**




NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
DATA SOURCE: CDC/NCHS, National Health Interview Survey, 1997–2014, Family Core component.

**Figure 5. Percentage of children under age 18 who were uninsured at the time of interview, by poverty status: United States, 1997–2014**




NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
DATA SOURCE: CDC/NCHS, National Health Interview Survey, 1997–2014, Family Core component.

was noted in the percentage of persons under age 65 covered by plans obtained through the Health Insurance Marketplace or state-based exchanges, from 1.4% (3.7 million) in the first quarter of 2014 (January through March) to 2.5% (6.7 million) in the fourth quarter of 2014 (October through December) (Figure 3).

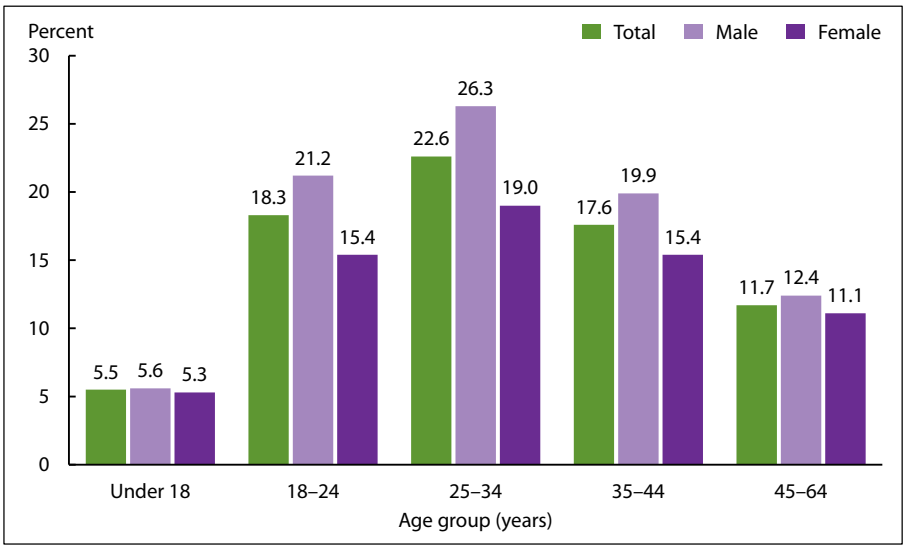
Additional Health Insurance Marketplace or state-based exchange estimates by age, sex, race/ethnicity, and poverty status are available for the fourth quarter of 2014 (based on data collected from October through December) through the Early Release Program (http://www.cdc.gov/nchs/data/nhis/earlyrelease/Q_Estimates_2010_2014_Q 4.pdf).

More than two-thirds of adults aged 18–64 were covered by a private plan (67.3%), compared with 53.7% of children under age 18 (Table 3 and Figure 1). Among adults aged 19–25, 61.9% were covered by a private plan. Among adults aged 18–64, 2.7% (5.2 million) were covered by private plans obtained through the Health Insurance Marketplace or state-based exchanges. Among children under age 18 and adults aged 19–25, 0.9% and 1.9%, respectively, were covered by private plans obtained through the Health Insurance Marketplace or state-based exchanges. Among children under age 18, adults aged 18–29, and adults aged 30–64, a significant increase was seen in the percentages with private coverage obtained through the Health Insurance Marketplace or state-based exchanges between the first quarter of 2014 (January through March) and the fourth quarter of 2014 (October through December) (Figure 3).

For all age groups except children aged 0–17, increases were observed between 2013 and 2014 in the percentage of persons covered by a private plan (Table 3).

The percentage with private coverage generally decreased among persons under age 65 between 1997 and 2014 (Table 3) but remained stable from 2010 to 2013. Among adults aged 18–64, private coverage was more than 5 percentage points lower in 2014 (67.3%) than in 1997 (72.8%). Among children, private coverage decreased between 1997 (66.2%) and 2014 (53.7%).

**Figure 6. Percentage of persons under age 65 without health insurance coverage at the time of interview, by age group and sex: United States, 2014**




NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
DATA SOURCE: CDC/NCHS, National Health Interview Survey, 2014, Family Core component.

## Health insurance coverage, by poverty status

In 2014, 22.3% of poor, 23.5% of near-poor, and 7.6% of not-poor persons under age 65 did not have health insurance coverage at the time of interview (Table 4; see Technical Notes for a definition of poverty status). During the same period, 62.1% of poor, 41.1% of near-poor, and 9.9% of not-poor persons in this age group had public coverage. Private coverage was highest among those who were not-poor (83.7%) and lowest among those who were poor (16.6%).

Among adults aged 18–64, 32.3% of poor, 30.9% of near-poor, and 8.9% of not-poor adults did not have health insurance coverage at the time of interview (Table 5). During the same period, 46.6% of poor, 29.6% of near-poor, and 8.5% of not-poor adults in this age group had public coverage. Private coverage was highest among those who were not-poor (83.9%) and lowest among those who were poor (21.9%).

Among children aged 0–17, 5.9% of poor, 8.6% of near-poor, and 3.6% of not-poor children did not have health insurance coverage at the time of interview (Table 6). During the same period, 87.3% of poor, 64.3% of near-poor, and 14.4% of not-poor children had public coverage. Private coverage among children was highest among those who were not-poor (83.1%) and lowest among those who were poor (8.0%).

Among persons under age 65 who were poor, near-poor, or not-poor, a significant decrease was seen in the percentage who were uninsured between 2013 and 2014 (Table 4). For poor persons under age 65, an increase was noted from 2013 to 2014 in the percentage of persons with public coverage, from 59.0% to 62.1%. For near-poor and not-poor persons under age 65, significant increases were seen between 2013 and 2014 in the percentage of persons covered by a private plan.

Among adults aged 18–64, for every poverty status group, a significant decrease was seen in the percentage who were uninsured between 2013 and 2014 (Table 5). Among poor adults aged 18–64, the percentage who were uninsured decreased from 39.3% to 32.3%, the percentage with public coverage increased from 42.4% to 46.6%, and the percentage with private coverage increased from 19.0% to 21.9% from 2013 to 2014.

Among adults in this age group who were near-poor, the percentage who were uninsured decreased from 38.5% to 30.9%, the percentage with public coverage increased from 26.6% to 29.6%, and the percentage with private coverage

increased from 36.4% to 41.2% between 2013 and 2014.

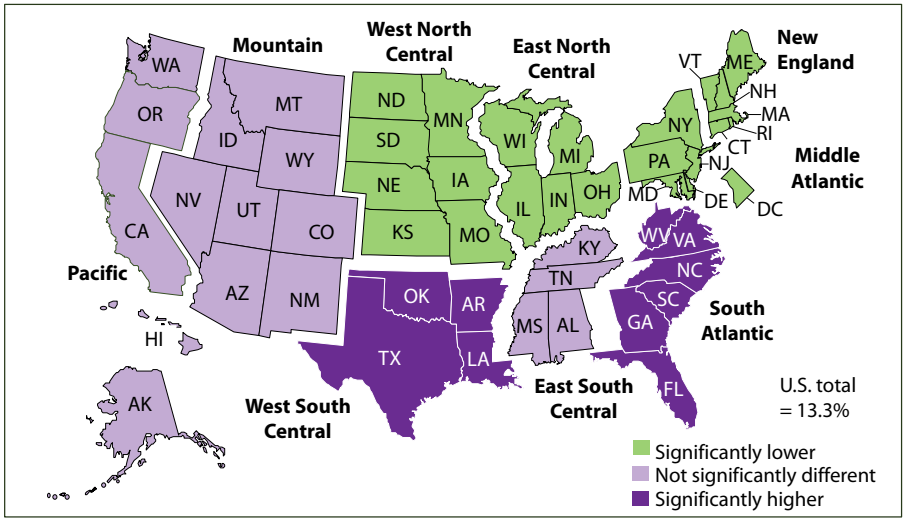
Among adults aged 18–64 who were not-poor, the percentage who were uninsured decreased from 11.4% to 8.9% between 2013 and 2014. Private coverage increased from 81.2% in 2013 to 83.9% in 2014. There was no change in the percentage with public coverage from 2013 to 2014.

Among poor and near-poor children, a significant decrease was noted in the percentages who were uninsured between 2013 and 2014 (Table 6). The percentage who were uninsured decreased from 7.8% to 5.9% among poor children between 2013 and 2014. Among near-poor children, the percentage who were uninsured decreased from 10.6% to 8.6% between 2013 and 2014. There were no significant changes in public coverage among poor, near-poor, and not-poor children between 2013 and 2014. Among not-poor children, the percentage with private coverage increased from 81.2% in 2013 to 83.1% in 2014. There were no significant changes in private coverage among children who were poor or near-poor between 2013 and 2014.

The percentage of poor adults aged 18–64 who were uninsured remained relatively stable from 1997 through 2013, with a significant decrease between 2013 and 2014 (Figure 4). Among near-poor and not-poor adults in this age group, a generally increasing trend was seen from 1997 to 2010 in the percentage who were uninsured. However, there has been a decreasing trend from 2010 to 2014 in the uninsured among near-poor and not-poor adults.

The percentage of poor and near-poor children who were uninsured at the time of interview decreased from 1997 through 2014 (Figure 5). However, the rate of decline during this period was greater for poor children. The percentage of near-poor children who were uninsured at the time of interview decreased from 1997 to 2003, remained relatively stable from 2003 to 2006, and then decreased from 2006 through 2014. The percentage of not-poor children who were uninsured at the time of interview has generally decreased from 6.1% in 1997 to 3.6% in 2014.

**Figure 8. Uninsured at the time of interview, comparing expanded regions and national percentages for persons under age 65: United States, 2014**




NOTES: Expanded regions are based on a subdivision of the four census regions into nine divisions. For this report, the nine census divisions were modified by moving Delaware, the District of Columbia, and Maryland into the Middle Atlantic Division. Data are based on household interviews of a sample of the civilian noninstitutionalized population.
DATA SOURCE: CDC/NCHS, National Health Interview Survey, 2014, Family Core component.

## Health insurance coverage, by selected demographic characteristics

### Age and sex

In 2014, adults aged 25–34 were the most likely (22.6%) to lack health insurance coverage at the time of interview (Table 7). Among persons under age 65, children aged 0–17 were the most likely to have public coverage (42.2%), and adults aged 45–64 were the most likely to have private coverage (71.5%). Among adults in age groups 18–24, 25–34, 35–44, and 45–64, men were more likely than women to lack health insurance coverage at the time of interview (Figure 6).

### Race/ethnicity

In 2014, among persons under age 65, 25.2% of Hispanic, 13.5% of non-Hispanic black, 10.6% of non-Hispanic Asian, and 9.8% of non-Hispanic white persons were uninsured at the time of interview (Table 8). Public coverage was highest among those who were non-Hispanic black (40.3%). Private coverage was highest among those who were non-Hispanic white (73.6%) and non-Hispanic Asian (73.4%).

For Hispanic persons under age 65, the percentage uninsured decreased from 30.3% in 2013 to 25.2% in 2014. For non-Hispanic white persons under age 65, the percentage uninsured decreased from 12.1% in 2013 to 9.8% in 2014. For non-Hispanic black persons under age 65, the percentage uninsured decreased from 18.9% in 2013 to 13.5% in 2014. For non-Hispanic Asian persons under age 65, the percentage uninsured decreased from 13.8% in 2013 to 10.6% in 2014.

### Other demographic characteristics

Among adults aged 18–64 who lacked a high school diploma, 34.0% were uninsured at the time of interview (Table 9). This rate is greater than three times the rate for those with more than a high school education (10.0%). Public health plan coverage was highest among those who lacked a high school diploma (34.0%) and lowest among those with more than a high school education (12.2%). Private coverage was highest among those who had more than a high school education (79.1%) and lowest among those who lacked a high school diploma (33.3%).

Among currently unemployed adults aged 18–64, 38.7% lacked coverage at the time of interview (Table 9). Among employed adults in the same age group, 14.9% were uninsured. Public health plan coverage was lowest among employed adults (9.5%) and highest among those who were not in the workforce (41.0%). Among employed

adults, 76.2% had private coverage. This rate is almost three times as high as for those who were unemployed (29.6%).

Adults aged 18–64 with family income less than 100%, and between 100% and up to and including 138%, of the federal poverty level (FPL) were the most likely to be uninsured relative to other income groups. Adults aged 18–64 with family incomes less than 100% FPL were the most likely to have public coverage. Those with family income greater than 400% FPL were the most likely to have private health insurance coverage.

Married adults aged 18–64 were less likely to be uninsured at the time of interview than those who were widowed, divorced, separated, living with a partner, or never married. Married adults were also more likely than other marital groups to have private health coverage.

## Estimates of enrollment in HDHPs, CDHPs, and FSAs

In 2014, 36.9% of persons under age 65 with private health insurance were enrolled in an HDHP, including 13.3% who were enrolled in a CDHP (an HDHP with a health savings account [HSA]) and 23.6% who were enrolled in an HDHP without an HSA (Figure 7 and Table 10). (See Technical Notes for definitions of HDHP, CDHP, and HSA.) Among those with private insurance, the percentage who were enrolled in an HDHP increased between 2013 (33.9%) and 2014 (36.9%).

HDHPs constitute a significant share of both employment-based and directly purchased health plans. Based on data from 2014, among persons under age 65 with private health insurance, 36.2% with employment-based coverage were enrolled in an HDHP (Table 11), an increase from 2013 (32.0%). Also in that age group, 54.1% with directly purchased private health plans were enrolled in an HDHP in 2014. This was a decrease from 2013 (56.4%).

In 2014, among persons under age 65 with private health insurance, 21.2% were in a family that had an FSA for medical expenses (Table 10). (See Technical Notes for definition of FSA.)

## Health insurance coverage, by state Medicaid expansion status

Under provisions of ACA, states have the option to expand Medicaid coverage to those with low income. Health insurance estimates by state Medicaid expansion status (as of October 31, 2013), including the District of Columbia, are presented for all persons under age 65, children aged 0–17, and adults aged 18–64 (Table 12). (See Technical Notes for definitions of Medicaid expansion status.)

In 2014, adults aged 18–64 residing in Medicaid expansion states were less likely to be uninsured than those residing in nonexpansion states. In Medicaid expansion states, the percentage of those uninsured decreased from 18.4% in 2013 to 13.3% in 2014. In nonexpansion states, the percentage uninsured decreased from 22.7% in 2013 to 19.6% in 2014.

In 2014, adults aged 18–64 in Medicaid expansion states were more likely to have public coverage (19.9%) than those in nonexpansion states (15.3%). In Medicaid expansion states, an increase was observed in public coverage from 17.7% in 2013 to 19.9% in 2014. In nonexpansion states, there was no significant change in public coverage between 2013 and 2014.

In 2014, among adults aged 18–64, those in Medicaid expansion states were more likely to have private coverage (68.1%) than those in nonexpansion states (66.5%). Among adults aged 18–64 in Medicaid expansion states, the percentage with private coverage increased from 65.2% in 2013 to 68.1% in 2014. Among adults aged 18–64 in nonexpansion states, the percentage with private coverage increased from 63.2% in 2013 to 66.5% in 2014.

## Health insurance coverage, by state Health Insurance Marketplace type

Health insurance estimates by state Health Insurance Marketplace type (as of October 31, 2013), including the District of Columbia, are presented for all persons under age 65, children aged 0–17, and adults aged 18–64 (Table 13). (See Technical Notes for definitions of Marketplace types.) In 2014, adults aged 18–64 in states with a federally facilitated Marketplace were more likely to be uninsured than those in states with a state-based Marketplace or states with a partnership Marketplace. Decreases were seen in the uninsured rates between 2013 and 2014 in states with a state-based Marketplace, a partnership Marketplace, and a federally facilitated Marketplace for persons under age 65 and for adults aged 18–64. For children in states with a state-based Marketplace, a decrease was noted in the uninsured rate between 2013 and 2014.

In 2014, adults aged 18–64 in states with a state-based Marketplace were more likely to have public coverage than those in states with a partnership Marketplace or federally facilitated Marketplace. Among those in states with a state-based Marketplace, the percentage with public coverage increased from 18.4% in 2013 to 20.6% in 2014. There were no significant changes between 2013 and 2014 in the percentages of adults aged 18–64 with public coverage in states with a partnership Marketplace or federally facilitated Marketplace.

In 2014, adults aged 18–64 in states with a partnership Marketplace were more likely to have private coverage than those in states with state-based exchanges or those in states with a federally facilitated Marketplace. Among those in states with a federally facilitated Marketplace, the percentage with private coverage increased from 63.6% in 2013 to 66.9% in 2014. Among those in states with a state-based Marketplace, the percentage with private coverage increased from 64.1% in 2013 to 67.0% in 2014.

## Health insurance coverage in regions and states

The U.S. Census Bureau divides the United States into four regions. Based on data from 2014 NHIS, lack of health insurance coverage at the time of interview among adults aged 18–64 was greatest in the South region (20.7%) (Table 9). The highest rates of public coverage were in the Northeast (19.2%) and West (18.9%), and the highest rates of private coverage were in the Northeast (70.9%) and Midwest (71.9%).

Alternatively, the United States may be divided into nine expanded regions (Figure 8). Table 14 presents health insurance estimates for persons of all ages, persons under age 65, adults aged 18–64, and children aged 0–17 for these nine expanded regions. (See Technical Notes for definitions of the expanded regions, which are similar to but not exactly the same as Census divisions.)

In 2014, for persons under age 65, rates of uninsurance at the time of interview were significantly higher than the national average of 13.3% in the South Atlantic and West South Central regions (Table 7). By contrast, rates of uninsurance were significantly lower than the national average in the New England, Middle Atlantic, East North Central, and West North Central regions.

In the United States overall, 24.5% of persons under age 65 had public coverage. Public coverage rates for this age group ranged from 19.1% in the West North Central region to 29.5% in the East South Central region (Table 14). The West North Central and West South Central regions had rates that were significantly lower than the national average. The East South Central and Pacific regions had rates that were significantly above the national average.

In the United States overall, 63.6% of persons under age 65 had private coverage. Private coverage rates for this age group ranged from 58.5% in the West South Central region to 72.4% in the West North Central region (Table 14). The New England, Middle Atlantic, East North Central, and West North Central regions had rates significantly above the national average. In contrast, rates of private coverage were significantly lower than the national average in the South Atlantic and West South Central regions.

State-specific health insurance estimates are presented for all 50 states and the District of Columbia for persons of all ages, persons under age 65, and adults aged 18–64, and for 40 states for children aged 0–17 (Table 15). Estimates are not presented for all 50 states and the District of Columbia for children due to considerations of sample size and precision.

Nationally, in 2014, 13.3% of persons under age 65 lacked health insurance coverage at the time of interview (Table 15). Rates of uninsurance were significantly higher than the national average in Alaska, Arizona, Florida, Mississippi, Nevada, North Carolina, Oklahoma, and Texas. By contrast, rates of uninsurance at the time of interview in Connecticut, Delaware, District of Columbia, Hawaii, Iowa, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New York, North Dakota, Ohio, Pennsylvania, Rhode Island, Vermont, West Virginia, and Wisconsin were significantly lower than the national average of 13.3%.

In the United States overall in 2014, 5.5% of children lacked coverage at the time of interview, but among the 40 states shown in Table 15, rates were significantly higher than the national average in Arizona, Nevada, Oklahoma, Texas, and Utah. In contrast, rates of uninsurance at the time of interview in Indiana, Maryland, Massachusetts, Michigan, Minnesota, Pennsylvania, and West Virginia were significantly lower than the national average of 5.5%.

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**Table 1. Percentages of persons who lacked health insurance coverage at the time of interview, for at least part of the past year, and for more than a year, by age group and year: United States, 2009–2014**

| Age group and year | Uninsured[1] at the time of interview | Uninsured[1] for at least part of the past year[2] | Uninsured[1] for more than a year[2] |
|---|---|---|---|
| | Percent (standard error) | | |
| All ages | | | |
| 2009 | 15.4 (0.30) | 19.4 (0.32) | 10.9 (0.26) |
| 2010 | 16.0 (0.27) | 19.8 (0.29) | 11.7 (0.22) |
| 2011 | 15.1 (0.25) | 19.2 (0.29) | 11.2 (0.21) |
| 2012 | 14.7 (0.23) | 18.6 (0.27) | 11.1 (0.22) |
| 2013 | 14.4 (0.26) | 17.8 (0.27) | 10.7 (0.23) |
| 2014 | 11.5 (0.23) | 16.5 (0.25) | 8.4 (0.19) |
| Under 65 years | | | |
| 2009 | 17.5 (0.34) | 22.0 (0.36) | 12.4 (0.29) |
| 2010 | 18.2 (0.30) | 22.5 (0.33) | 13.3 (0.24) |
| 2011 | 17.3 (0.29) | 21.8 (0.33) | 12.7 (0.25) |
| 2012 | 16.9 (0.27) | 21.3 (0.31) | 12.7 (0.24) |
| 2013 | 16.6 (0.30) | 20.4 (0.32) | 12.4 (0.27) |
| 2014 | 13.3 (0.26) | 19.0 (0.29) | 9.7 (0.22) |
| 0–17 years | | | |
| 2009 | 8.2 (0.40) | 12.8 (0.47) | 4.8 (0.31) |
| 2010 | 7.8 (0.32) | 11.6 (0.37) | 4.5 (0.23) |
| 2011 | 7.0 (0.27) | 10.9 (0.36) | 3.7 (0.19) |
| 2012 | 6.6 (0.27) | 10.4 (0.35) | 3.7 (0.19) |
| 2013 | 6.5 (0.26) | 10.0 (0.33) | 3.6 (0.20) |
| 2014 | 5.5 (0.27) | 9.4 (0.40) | 3.0 (0.19) |
| 18–64 years | | | |
| 2009 | 21.1 (0.37) | 25.6 (0.38) | 15.4 (0.34) |
| 2010 | 22.3 (0.35) | 26.7 (0.37) | 16.8 (0.30) |
| 2011 | 21.3 (0.34) | 26.0 (0.37) | 16.3 (0.31) |
| 2012 | 20.9 (0.31) | 25.5 (0.34) | 16.2 (0.29) |
| 2013 | 20.4 (0.37) | 24.4 (0.38) | 15.7 (0.34) |
| 2014 | 16.3 (0.31) | 22.6 (0.34) | 12.3 (0.27) |
| 19–25 years | | | |
| 2009 | 32.7 (0.82) | 40.3 (0.87) | 22.0 (0.74) |
| 2010 | 33.9 (0.73) | 41.7 (0.78) | 24.1 (0.61) |
| 2011 | 27.9 (0.71) | 36.1 (0.77) | 20.1 (0.61) |
| 2012 | 26.4 (0.72) | 33.0 (0.72) | 19.6 (0.62) |
| 2013 | 26.5 (0.71) | 31.3 (0.79) | 19.8 (0.61) |
| 2014 | 20.0 (0.65) | 26.9 (0.73) | 14.2 (0.56) |

[1]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[2]In references to "part of the past year" and "more than a year," a year is defined as the 12 months prior to interview.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

DATA SOURCE: CDC/NCHS, National Health Interview Survey, 2009–2014, Family Core component.

**Table 2. Numbers of persons who lacked health insurance coverage at the time of interview, for at least part of the past year, and for more than a year, by age group and year: United States, 2014**

| Age group and year | Uninsured[1] at the time of interview | Uninsured[1] for at least part of the past year[2] | Uninsured[1] for more than a year[2] |
|---|---|---|---|
| | Number (millions) | | |
| All ages | | | |
| 2009 | 46.3 | 58.5 | 32.8 |
| 2010 | 48.6 | 60.3 | 35.7 |
| 2011 | 46.3 | 58.7 | 34.2 |
| 2012 | 45.5 | 57.5 | 34.1 |
| 2013 | 44.8 | 55.4 | 33.4 |
| 2014 | 36.0 | 51.6 | 26.3 |
| Under 65 years | | | |
| 2009 | 46.0 | 57.9 | 32.6 |
| 2010 | 48.2 | 59.6 | 35.4 |
| 2011 | 45.9 | 58.0 | 33.9 |
| 2012 | 45.2 | 56.8 | 33.9 |
| 2013 | 44.3 | 54.7 | 33.1 |
| 2014 | 35.7 | 50.8 | 26.1 |
| 0–17 years | | | |
| 2009 | 6.1 | 9.5 | 3.6 |
| 2010 | 5.8 | 8.7 | 3.4 |
| 2011 | 5.2 | 8.1 | 2.7 |
| 2012 | 4.9 | 7.7 | 2.7 |
| 2013 | 4.8 | 7.3 | 2.6 |
| 2014 | 4.0 | 6.9 | 2.2 |
| 18–64 years | | | |
| 2009 | 40.0 | 48.4 | 29.1 |
| 2010 | 42.5 | 51.0 | 32.0 |
| 2011 | 40.7 | 49.9 | 31.2 |
| 2012 | 40.3 | 49.2 | 31.2 |
| 2013 | 39.6 | 47.4 | 30.5 |
| 2014 | 31.7 | 44.0 | 23.9 |
| 19–25 years | | | |
| 2009 | 9.5 | 11.6 | 6.4 |
| 2010 | 10.0 | 12.3 | 7.1 |
| 2011 | 8.4 | 10.8 | 6.0 |
| 2012 | 7.9 | 9.9 | 5.9 |
| 2013 | 8.0 | 9.5 | 6.0 |
| 2014 | 6.0 | 8.1 | 4.3 |

[1]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[2]In references to "part of the past year" and "more than a year," a year is defined as the 12 months prior to interview.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

DATA SOURCE: CDC/NCHS, National Health Interview Survey, 2009–2014, Family Core component.

**Table 3. Percentages of persons who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group and selected years: United States, 1997–2014**

| Age group and year | Uninsured[1] at the time of interview | Public health plan coverage[2] | Private health insurance coverage[3] |
|---|---|---|---|
| | Percent (standard error) | | |
| All ages | | | |
| 1997 | 15.4 (0.21) | 23.3 (0.27) | 70.7 (0.32) |
| 2005 | 14.2 (0.21) | 26.4 (0.30) | 67.3 (0.37) |
| 2009 | 15.4 (0.30) | 30.4 (0.40) | 61.9 (0.50) |
| 2010 | 16.0 (0.27) | 31.4 (0.39) | 60.2 (0.48) |
| 2011 | 15.1 (0.25) | 32.4 (0.37) | 60.1 (0.48) |
| 2012 | 14.7 (0.23) | 33.4 (0.35) | 59.6 (0.43) |
| 2013 | 14.4 (0.26) | 33.8 (0.36) | 59.5 (0.49) |
| 2014 | 11.5 (0.23) | 34.6 (0.37) | 61.8 (0.45) |
| Under 65 years | | | |
| 1997 | 17.4 (0.24) | 13.6 (0.25) | 70.8 (0.35) |
| 2005 | 16.0 (0.24) | 16.8 (0.29) | 68.4 (0.39) |
| 2009 | 17.5 (0.34) | 21.0 (0.39) | 62.9 (0.54) |
| 2010 | 18.2 (0.30) | 22.0 (0.38) | 61.2 (0.50) |
| 2011 | 17.3 (0.29) | 23.0 (0.37) | 61.2 (0.51) |
| 2012 | 16.9 (0.27) | 23.5 (0.37) | 61.0 (0.47) |
| 2013 | 16.6 (0.30) | 23.8 (0.35) | 61.0 (0.52) |
| 2014 | 13.3 (0.26) | 24.5 (0.36) | 63.6 (0.46) |
| 0–17 years | | | |
| 1997 | 13.9 (0.36) | 21.4 (0.48) | 66.2 (0.57) |
| 2005 | 8.9 (0.29) | 29.9 (0.56) | 62.4 (0.60) |
| 2009 | 8.2 (0.40) | 37.7 (0.76) | 55.7 (0.86) |
| 2010 | 7.8 (0.32) | 39.8 (0.73) | 53.8 (0.75) |
| 2011 | 7.0 (0.27) | 41.0 (0.74) | 53.3 (0.76) |
| 2012 | 6.6 (0.27) | 42.1 (0.72) | 52.8 (0.73) |
| 2013 | 6.5 (0.26) | 42.2 (0.70) | 52.6 (0.76) |
| 2014 | 5.5 (0.27) | 42.2 (0.65) | 53.7 (0.68) |
| 18–64 years | | | |
| 1997 | 18.9 (0.23) | 10.2 (0.20) | 72.8 (0.30) |
| 2005 | 18.9 (0.26) | 11.5 (0.22) | 70.9 (0.36) |
| 2009 | 21.1 (0.37) | 14.4 (0.31) | 65.8 (0.47) |
| 2010 | 22.3 (0.35) | 15.0 (0.30) | 64.1 (0.46) |
| 2011 | 21.3 (0.34) | 15.9 (0.29) | 64.2 (0.45) |
| 2012 | 20.9 (0.31) | 16.4 (0.29) | 64.1 (0.42) |
| 2013 | 20.4 (0.37) | 16.7 (0.30) | 64.2 (0.47) |
| 2014 | 16.3 (0.31) | 17.7 (0.32) | 67.3 (0.43) |

See footnotes at end of table.

**Table 3. Percentages of persons who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group and selected years: United States, 1997–2014—*Continued***

| Age group and year | Uninsured[1] at the time of interview | Public health plan coverage[2] | Private health insurance coverage[3] |
|---|---|---|---|
| | Percent (standard error) | | |
| 19–25 years | | | |
| 1997 | 31.4 (0.63) | 11.2 (0.46) | 58.4 (0.71) |
| 2005 | 31.2 (0.65) | 12.9 (0.51) | 56.5 (0.79) |
| 2009 | 32.7 (0.82) | 15.0 (0.62) | 52.6 (0.91) |
| 2010 | 33.9 (0.73) | 15.7 (0.55) | 51.0 (0.84) |
| 2011 | 27.9 (0.71) | 16.8 (0.60) | 56.2 (0.85) |
| 2012 | 26.4 (0.72) | 17.5 (0.59) | 57.2 (0.85) |
| 2013 | 26.5 (0.71) | 16.1 (0.54) | 58.1 (0.84) |
| 2014 | 20.0 (0.65) | 19.1 (0.64) | 61.9 (0.88) |

[1]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[2]Includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[3]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

DATA SOURCE: CDC/NCHS, National Health Interview Survey, 1997, 2005, and 2009–2014, Family Core component.

**Table 4. Percentages of persons under age 65 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by poverty status and year: United States, 2009–2014**

| Poverty status[1] and year | Uninsured[2] at the time of interview | Public health plan coverage[3] | Private health insurance coverage[4] |
|---|---|---|---|
| | Percent (standard error) | | |
| Poor (<100% FPL) | | | |
| 2009 | 30.2 (0.89) | 56.7 (1.06) | 14.1 (0.87) |
| 2010 | 29.5 (0.83) | 56.0 (0.98) | 15.5 (0.70) |
| 2011 | 28.2 (0.66) | 56.2 (0.82) | 16.6 (0.77) |
| 2012 | 28.3 (0.65) | 57.1 (0.83) | 16.1 (0.83) |
| 2013 | 27.3 (0.68) | 59.0 (0.81) | 14.7 (0.72) |
| 2014 | 22.3 (0.66) | 62.1 (0.80) | 16.6 (0.69) |
| Near-poor (≥100% and <200% FPL) | | | |
| 2009 | 29.4 (0.77) | 36.7 (0.85) | 35.9 (0.93) |
| 2010 | 32.3 (0.69) | 36.2 (0.63) | 33.2 (0.77) |
| 2011 | 30.4 (0.58) | 37.7 (0.73) | 33.5 (0.75) |
| 2012 | 29.5 (0.56) | 37.1 (0.66) | 35.2 (0.75) |
| 2013 | 29.3 (0.70) | 39.1 (0.77) | 33.4 (0.79) |
| 2014 | 23.5 (0.60) | 41.1 (0.74) | 37.3 (0.81) |
| Not-poor (≥200% FPL) | | | |
| 2009 | 10.7 (0.29) | 9.0 (0.30) | 81.6 (0.42) |
| 2010 | 10.7 (0.24) | 9.7 (0.28) | 81.0 (0.36) |
| 2011 | 10.1 (0.25) | 9.9 (0.26) | 81.4 (0.36) |
| 2012 | 9.8 (0.23) | 10.3 (0.33) | 81.3 (0.39) |
| 2013 | 9.6 (0.24) | 10.5 (0.29) | 81.2 (0.39) |
| 2014 | 7.6 (0.20) | 9.9 (0.28) | 83.7 (0.36) |
| Unknown | | | |
| 2009 | 22.3 (0.85) | 20.8 (0.88) | 57.9 (1.24) |
| 2010 | 22.7 (0.95) | 21.0 (0.69) | 57.3 (1.08) |
| 2011 | 21.0 (0.64) | 26.2 (0.95) | 53.9 (1.09) |
| 2012 | 20.4 (0.73) | 28.8 (0.89) | 52.1 (1.00) |
| 2013 | 20.5 (0.76) | 24.2 (0.94) | 56.8 (1.24) |
| 2014 | 15.0 (0.80) | 22.2 (0.91) | 64.1 (1.24) |

[1]FPL is federal poverty level. Based on family income and family size, using the U.S. Census Bureau's poverty thresholds. "Poor" persons are defined as those with incomes below the poverty threshold; "Near-poor" persons have incomes of 100% to less than 200% of the poverty threshold; and "Not-poor" persons have incomes of 200% of the poverty threshold or greater. For more information on the "Unknown" poverty status category, see Technical Notes. Estimates may differ from estimates that are based on both reported and imputed income.

[2]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan at the time of interview. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[3]Includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[4]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

DATA SOURCE: CDC/NCHS, National Health Interview Survey, 2009–2014, Family Core component.

**Table 5. Percentages of adults aged 18–64 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by poverty status and year: United States, 2009–2014**

| Poverty status[1] and year | Uninsured[2] at the time of interview | Public health plan coverage[3] | Private health insurance coverage[4] |
|---|---|---|---|
| | Percent (standard error) | | |
| Poor (<100% FPL) | | | |
| 2009 | 42.5 (1.20) | 40.3 (1.21) | 18.0 (1.15) |
| 2010 | 42.2 (0.99) | 38.8 (0.97) | 19.6 (0.89) |
| 2011 | 40.1 (0.92) | 39.6 (0.93) | 21.2 (1.02) |
| 2012 | 40.1 (0.90) | 40.8 (0.94) | 20.2 (1.09) |
| 2013 | 39.3 (1.00) | 42.4 (0.95) | 19.0 (0.97) |
| 2014 | 32.3 (0.93) | 46.6 (0.95) | 21.9 (0.92) |
| Near-poor (≥100% and <200% FPL) | | | |
| 2009 | 39.1 (0.85) | 24.5 (0.75) | 37.7 (0.84) |
| 2010 | 43.0 (0.74) | 23.7 (0.55) | 34.7 (0.74) |
| 2011 | 40.1 (0.72) | 25.9 (0.69) | 35.4 (0.75) |
| 2012 | 39.2 (0.68) | 25.2 (0.57) | 37.2 (0.74) |
| 2013 | 38.5 (0.84) | 26.6 (0.78) | 36.4 (0.78) |
| 2014 | 30.9 (0.72) | 29.6 (0.76) | 41.2 (0.81) |
| Not-poor (≥200% FPL) | | | |
| 2009 | 12.5 (0.31) | 7.6 (0.26) | 81.4 (0.38) |
| 2010 | 12.6 (0.27) | 8.1 (0.27) | 80.8 (0.36) |
| 2011 | 12.0 (0.28) | 8.3 (0.23) | 81.1 (0.35) |
| 2012 | 11.4 (0.26) | 8.7 (0.29) | 81.3 (0.38) |
| 2013 | 11.4 (0.27) | 8.9 (0.26) | 81.2 (0.37) |
| 2014 | 8.9 (0.23) | 8.5 (0.26) | 83.9 (0.35) |
| Unknown | | | |
| 2009 | 26.7 (0.99) | 15.5 (0.69) | 58.8 (1.13) |
| 2010 | 27.1 (1.10) | 15.6 (0.63) | 58.4 (1.11) |
| 2011 | 25.6 (0.77) | 17.6 (0.73) | 58.1 (0.96) |
| 2012 | 25.7 (0.88) | 18.9 (0.76) | 56.9 (0.92) |
| 2013 | 24.3 (0.87) | 17.6 (0.77) | 59.5 (1.11) |
| 2014 | 17.2 (0.88) | 17.2 (0.81) | 67.0 (1.20) |

[1]FPL is federal poverty level. Based on family income and family size, using the U.S. Census Bureau's poverty thresholds. "Poor" persons are defined as those with incomes below the poverty threshold; "Near-poor" persons have incomes of 100% to less than 200% of the poverty threshold; and "Not-poor" persons have incomes of 200% of the poverty threshold or greater. For more information on the "Unknown" poverty status category, see Technical Notes. Estimates may differ from estimates that are based on both reported and imputed income.

[2]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan at the time of interview. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[3]Includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[4]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

DATA SOURCE: CDC/NCHS, National Health Interview Survey, 2009–2014, Family Core component.

**Table 6. Percentages of children aged 0–17 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by poverty status and year: United States, 2009–2014**

| Poverty status[1] and year | Uninsured[2] at the time of interview | Public health plan coverage[3] | Private health insurance coverage[4] |
|---|---|---|---|
| | Percent (standard error) | | |
| Poor (<100% FPL) | | | |
| 2009 | 11.8 (0.94) | 81.4 (1.11) | 8.2 (0.81) |
| 2010 | 10.2 (0.96) | 82.0 (1.22) | 9.2 (0.70) |
| 2011 | 8.1 (0.62) | 84.4 (0.87) | 8.9 (0.72) |
| 2012 | 7.5 (0.58) | 85.9 (0.80) | 8.8 (0.78) |
| 2013 | 7.8 (0.62) | 86.1 (0.88) | 7.7 (0.69) |
| 2014 | 5.9 (0.52) | 87.3 (0.72) | 8.0 (0.62) |
| Near-poor (≥100% and <200% FPL) | | | |
| 2009 | 12.1 (0.90) | 58.4 (1.42) | 32.8 (1.43) |
| 2010 | 12.6 (0.73) | 59.2 (1.16) | 30.5 (1.18) |
| 2011 | 11.5 (0.69) | 60.8 (1.17) | 29.9 (1.07) |
| 2012 | 10.1 (0.70) | 61.0 (1.30) | 31.1 (1.18) |
| 2013 | 10.6 (0.72) | 64.4 (1.16) | 27.3 (1.17) |
| 2014 | 8.6 (0.65) | 64.3 (1.23) | 29.4 (1.19) |
| Not-poor (≥200% FPL) | | | |
| 2009 | 5.0 (0.39) | 13.7 (0.63) | 82.4 (0.73) |
| 2010 | 4.6 (0.29) | 14.9 (0.57) | 81.4 (0.61) |
| 2011 | 4.0 (0.27) | 15.0 (0.55) | 82.1 (0.58) |
| 2012 | 4.5 (0.31) | 15.2 (0.62) | 81.3 (0.64) |
| 2013 | 4.0 (0.28) | 15.6 (0.62) | 81.2 (0.65) |
| 2014 | 3.6 (0.28) | 14.4 (0.56) | 83.1 (0.58) |
| Unknown | | | |
| 2009 | 9.8 (0.99) | 36.1 (2.05) | 55.3 (2.07) |
| 2010 | 8.8 (0.89) | 38.1 (1.71) | 53.7 (1.74) |
| 2011 | 10.4 (0.76) | 45.9 (1.70) | 44.5 (1.66) |
| 2012 | 8.2 (0.77) | 51.8 (1.50) | 41.2 (1.49) |
| 2013 | 9.2 (1.00) | 43.7 (2.16) | 48.6 (2.20) |
| 2014 | 8.0 (1.41) | 37.9 (2.01) | 54.8 (2.05) |

[1]FPL is federal poverty level. Based on family income and family size, using the U.S. Census Bureau's poverty thresholds. "Poor" persons are defined as those with incomes below the poverty threshold; "Near-poor" persons have incomes of 100% to less than 200% of the poverty threshold; and "Not-poor" persons have incomes of 200% of the poverty threshold or greater. For more information on the "Unknown" poverty status category, see Technical Notes. Estimates may differ from estimates that are based on both reported and imputed income.

[2]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan at the time of interview. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[3]Includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[4]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

DATA SOURCE: CDC/NCHS, National Health Interview Survey, 2009–2014, Family Core component.

**Table 7. Percentages of persons who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group and sex: United States, 2014**

| Age group and sex | Uninsured[1] at the time of interview | Public health plan coverage[2] | Private health insurance coverage[3] |
|---|---|---|---|
| | Percent (standard error) | | |
| Age group (years) | | | |
| All ages | 11.5 (0.23) | 34.6 (0.37) | 61.8 (0.45) |
| Under 65 | 13.3 (0.26) | 24.5 (0.36) | 63.6 (0.46) |
| 0–17 | 5.5 (0.27) | 42.2 (0.65) | 53.7 (0.68) |
| 18–64 | 16.3 (0.31) | 17.7 (0.32) | 67.3 (0.43) |
| 18–24 | 18.3 (0.61) | 20.9 (0.67) | 61.8 (0.84) |
| 25–34 | 22.6 (0.52) | 16.3 (0.49) | 61.9 (0.64) |
| 35–44 | 17.6 (0.51) | 14.4 (0.42) | 68.5 (0.64) |
| 45–64 | 11.7 (0.31) | 18.9 (0.42) | 71.5 (0.50) |
| 65 and over | 0.8 (0.09) | 95.0 (0.24) | 51.2 (0.84) |
| 19–25 | 20.0 (0.65) | 19.1 (0.64) | 61.9 (0.88) |
| Sex | | | |
| Male: | | | |
| All ages | 12.9 (0.28) | 32.2 (0.40) | 62.1 (0.48) |
| Under 65 | 14.7 (0.31) | 22.8 (0.39) | 63.8 (0.50) |
| 0–17 | 5.6 (0.33) | 42.0 (0.75) | 53.8 (0.76) |
| 18–64 | 18.3 (0.38) | 15.2 (0.36) | 67.7 (0.47) |
| 18–24 | 21.2 (0.90) | 17.2 (0.83) | 62.4 (1.14) |
| 25–34 | 26.3 (0.73) | 11.4 (0.52) | 63.0 (0.77) |
| 35–44 | 19.9 (0.68) | 11.5 (0.54) | 69.1 (0.79) |
| 45–64 | 12.4 (0.39) | 18.3 (0.52) | 71.4 (0.59) |
| 65 and over | 0.8 (0.13) | 94.4 (0.31) | 51.0 (0.94) |
| 19–25 | 23.1 (0.93) | 14.8 (0.77) | 62.8 (1.10) |
| Female: | | | |
| All ages | 10.2 (0.22) | 37.0 (0.39) | 61.5 (0.47) |
| Under 65 | 11.9 (0.26) | 26.1 (0.39) | 63.4 (0.49) |
| 0–17 | 5.3 (0.30) | 42.5 (0.72) | 53.6 (0.77) |
| 18–64 | 14.3 (0.30) | 20.1 (0.36) | 66.9 (0.46) |
| 18–24 | 15.4 (0.66) | 24.7 (0.91) | 61.1 (1.09) |
| 25–34 | 19.0 (0.59) | 21.0 (0.68) | 60.8 (0.74) |
| 35–44 | 15.4 (0.51) | 17.2 (0.51) | 67.9 (0.68) |
| 45–64 | 11.1 (0.34) | 19.4 (0.45) | 71.6 (0.54) |
| 65 and over | 0.8 (0.09) | 95.5 (0.29) | 51.4 (0.89) |
| 19–25 | 16.9 (0.70) | 23.4 (0.88) | 60.9 (1.08) |

[1]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan at the time of interview. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[2]Includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[3]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

DATA SOURCE: CDC/NCHS, National Health Interview Survey, 2014, Family Core component.

**Table 8. Percentages of persons under age 65 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by race/ethnicity and year: United States, 2009–2014**

| Race/ethnicity and year | Uninsured[1] at the time of interview | Public health plan coverage[2] | Private health insurance coverage[3] |
|---|---|---|---|
| | Percent (standard error) | | |
| Hispanic or Latino | | | |
| 2009 | 32.8 (0.86) | 30.6 (0.78) | 37.1 (0.89) |
| 2010 | 31.9 (0.72) | 32.0 (0.78) | 36.6 (0.81) |
| 2011 | 31.1 (0.68) | 33.6 (0.74) | 36.1 (0.82) |
| 2012 | 30.4 (0.71) | 34.0 (0.71) | 36.4 (0.74) |
| 2013 | 30.3 (0.66) | 33.4 (0.62) | 37.0 (0.76) |
| 2014 | 25.2 (0.59) | 34.6 (0.78) | 41.2 (0.89) |
| Non-Hispanic white, single race | | | |
| 2009 | 13.1 (0.34) | 15.6 (0.42) | 72.9 (0.57) |
| 2010 | 13.7 (0.30) | 16.4 (0.42) | 71.4 (0.57) |
| 2011 | 13.0 (0.32) | 17.1 (0.39) | 71.4 (0.55) |
| 2012 | 12.7 (0.28) | 17.3 (0.39) | 71.5 (0.51) |
| 2013 | 12.1 (0.29) | 17.9 (0.38) | 71.6 (0.53) |
| 2014 | 9.8 (0.25) | 18.1 (0.41) | 73.6 (0.50) |
| Non-Hispanic black, single race | | | |
| 2009 | 18.8 (0.59) | 34.9 (0.97) | 47.8 (0.99) |
| 2010 | 20.8 (0.63) | 36.3 (0.79) | 44.6 (0.84) |
| 2011 | 19.0 (0.51) | 36.9 (0.83) | 45.6 (0.85) |
| 2012 | 17.9 (0.50) | 38.2 (0.77) | 45.4 (0.79) |
| 2013 | 18.9 (0.51) | 37.5 (0.92) | 44.9 (1.01) |
| 2014 | 13.5 (0.49) | 40.3 (0.76) | 47.7 (0.86) |
| Non-Hispanic Asian, single race | | | |
| 2009 | 15.2 (0.93) | 13.0 (1.00) | 72.5 (1.36) |
| 2010 | 16.8 (0.76) | 14.9 (0.98) | 69.1 (1.17) |
| 2011 | 16.0 (0.89) | 17.6 (1.14) | 67.0 (1.40) |
| 2012 | 16.4 (0.93) | 16.6 (0.85) | 67.5 (1.24) |
| 2013 | 13.8 (0.81) | 17.5 (1.00) | 69.4 (1.27) |
| 2014 | 10.6 (0.61) | 16.7 (0.86) | 73.4 (1.01) |
| Non-Hispanic other races and multiple races | | | |
| 2009 | 19.9 (1.50) | 34.6 (1.96) | 48.2 (2.59) |
| 2010 | 22.4 (4.83) | 30.3 (2.14) | 48.7 (3.83) |
| 2011 | 19.1 (1.78) | 32.5 (1.60) | 50.6 (1.89) |
| 2012 | 16.4 (1.33) | 35.8 (1.77) | 50.8 (2.16) |
| 2013 | 16.0 (1.17) | 35.9 (1.75) | 50.1 (1.97) |
| 2014 | 12.8 (1.30) | 36.2 (1.69) | 52.7 (2.01) |

[1]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[2]Includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[3]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

DATA SOURCE: CDC/NCHS, National Health Interview Survey, 2009–2014, Family Core component.

**Table 9. Percentages of adults aged 18–64 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by selected demographic characteristics: United States, 2014**

| Selected characteristic | Uninsured[1] at the time of interview | Public health plan coverage[2] | Private health insurance coverage[3] |
|---|---|---|---|
| | Percent (standard error) | | |
| Race/ethnicity | | | |
| Hispanic or Latino | 33.7 (0.76) | 20.6 (0.73) | 46.4 (0.86) |
| Non-Hispanic: | | | |
| White, single race | 11.6 (0.29) | 14.6 (0.36) | 75.3 (0.47) |
| Black, single race | 17.7 (0.60) | 30.5 (0.73) | 53.4 (0.84) |
| Asian, single race | 12.5 (0.65) | 13.7 (0.84) | 74.5 (1.01) |
| Other races and multiple races | 19.5 (1.65) | 25.2 (1.51) | 56.9 (2.06) |
| Region | | | |
| Northeast | 11.2 (0.45) | 19.2 (0.83) | 70.9 (0.85) |
| Midwest | 12.9 (0.48) | 16.5 (0.66) | 71.9 (0.84) |
| South | 20.7 (0.62) | 17.1 (0.49) | 63.7 (0.75) |
| West | 16.3 (0.56) | 18.9 (0.69) | 66.0 (0.89) |
| Education | | | |
| Less than high school | 34.0 (0.88) | 34.0 (0.87) | 33.3 (0.85) |
| High school diploma or GED[4] | 22.2 (0.50) | 23.0 (0.53) | 56.2 (0.63) |
| More than high school | 10.0 (0.25) | 12.2 (0.29) | 79.1 (0.39) |
| Employment status | | | |
| Employed | 14.9 (0.32) | 9.5 (0.24) | 76.2 (0.39) |
| Unemployed | 38.7 (1.07) | 32.3 (1.13) | 29.6 (1.01) |
| Not in workforce | 15.4 (0.46) | 41.0 (0.66) | 47.1 (0.68) |
| Poverty status[5] | | | |
| <100% FPL | 32.3 (0.93) | 46.6 (0.95) | 21.9 (0.92) |
| ≥100% and ≤138% FPL | 33.8 (1.07) | 37.2 (1.09) | 30.3 (1.13) |
| >138% and ≤250% FPL | 25.8 (0.60) | 21.1 (0.64) | 54.9 (0.75) |
| >250% and ≤400% FPL | 12.6 (0.42) | 10.5 (0.43) | 78.3 (0.55) |
| >400% FPL | 4.1 (0.20) | 5.7 (0.29) | 91.3 (0.33) |
| Unknown | 14.8 (0.75) | 14.8 (0.71) | 71.8 (1.08) |
| Marital status | | | |
| Married | 12.0 (0.32) | 12.9 (0.34) | 76.4 (0.45) |
| Widowed | 17.5 (1.59) | 33.8 (1.91) | 51.2 (2.13) |
| Divorced or separated | 18.6 (0.54) | 27.9 (0.82) | 55.3 (0.84) |
| Living with partner | 27.7 (0.91) | 19.3 (0.75) | 54.0 (1.06) |
| Never married | 20.2 (0.46) | 22.3 (0.51) | 58.6 (0.65) |

[1]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[2]Includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[3]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

[4]GED is General Educational Development high school equivalency diploma.

[5]FPL is federal poverty level. Based on family income and family size, using the U.S. Census Bureau's poverty thresholds. The percentage of respondents with "Unknown" poverty status for this five-level categorization is 10.0%. This value is greater than the corresponding value for the three-level poverty categorization because of greater uncertainty when assigning individuals to more detailed poverty groups. For more information on poverty status, see Technical Notes. Estimates may differ from estimates that are based on both reported and imputed income.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

DATA SOURCE: CDC/NCHS, National Health Interview Survey, 2014, Family Core component.

**Table 10. Percentages of persons under age 65 with private health insurance coverage who were enrolled in a high-deductible health plan, in a high-deductible health plan without a health savings account, and in a consumer-directed health plan, and who were in a family with a flexible spending account for medical expenses, by year: United States, 2009–2014**

| Year | Enrolled in high-deductible health plan (HDHP)[1] | Enrolled in HDHP without health savings account (HSA)[2] | Enrolled in consumer-directed health plan (CDHP)[3] | In family with flexible spending account (FSA) for medical expenses |
|---|---|---|---|---|
| | Percent (standard error) | | | |
| 2009 | 22.5 (0.58) | 15.9 (0.43) | 6.6 (0.33) | 20.4 (0.50) |
| 2010 | 25.3 (0.54) | 17.6 (0.46) | 7.7 (0.33) | 20.4 (0.50) |
| 2011 | 29.0 (0.54) | 19.9 (0.41) | 9.2 (0.35) | 21.4 (0.53) |
| 2012 | 31.1 (0.57) | 20.3 (0.42) | 10.8 (0.34) | 21.6 (0.45) |
| 2013 | 33.9 (0.68) | 22.2 (0.48) | 11.7 (0.43) | 21.6 (0.48) |
| 2014 | 36.9 (0.77) | 23.6 (0.52) | 13.3 (0.47) | 21.2 (0.49) |

[1]An HDHP was defined in 2014 as a health plan with an annual deductible of at least $1,250 for self-only coverage and $2,500 for family coverage. The deductible is adjusted annually for inflation. Deductibles for previous years are included in Technical Notes.

[2]An HSA is a tax-advantaged account or fund that can be used to pay for medical expenses. It must be coupled with an HDHP.

[3]A CDHP is an HDHP coupled with an HSA.

NOTES: The measures of HDHP enrollment, CDHP enrollment, and being in a family with an FSA for medical expenses are not mutually exclusive. Therefore, a person may be counted in more than one measure. The individual components of HDHPs may not add up to the total due to rounding. Data are based on household interviews of a sample of the civilian noninstitutionalized population.

DATA SOURCE: CDC/NCHS, National Health Interview Survey, 2009–2014, Family Core component.

**Table 11. Percentage of persons under age 65 with private health insurance coverage who were enrolled in a high-deductible health plan, by year and source of coverage: United States, 2009–2014**

| Year | Employment-based[1] | Directly purchased[2] |
|---|---|---|
| | Percent (standard error) | |
| 2009 | 20.2 (0.59) | 46.9 (1.84) |
| 2010 | 23.3 (0.54) | 48.0 (1.48) |
| 2011 | 26.9 (0.53) | 52.4 (1.49) |
| 2012 | 29.2 (0.60) | 54.7 (1.61) |
| 2013 | 32.0 (0.67) | 56.4 (1.50) |
| 2014 | 36.2 (0.73) | 54.1 (1.43) |

[1]Private insurance that was originally obtained through a present or former employer or union, or through a professional association.

[2]Private insurance that was originally obtained through direct purchase or other means not related to employment.

NOTES: For persons under age 65, approximately 8% of private health plans were directly purchased from 2009 through 2013. In 2014, 10% of private plans were directly purchased. Data are based on household interviews of a sample of the civilian noninstitutionalized population.

DATA SOURCE: CDC/NCHS, National Health Interview Survey, 2009–2014, Family Core component.

**Table 12. Percentages of persons under age 65 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group, state Medicaid expansion status, and year: United States, 2009–2014**

| Age group, state Medicaid expansion status, and year | Uninsured[1] at the time of interview | Public health plan coverage[2] | Private health insurance coverage[3] |
|---|---|---|---|
| | Percent (standard error) | | |
| Under 65 years | | | |
| Medicaid expansion states[4] | | | |
| 2009 | 15.4 (0.37) | 20.7 (0.56) | 65.3 (0.73) |
| 2010 | 16.4 (0.42) | 21.8 (0.54) | 63.1 (0.70) |
| 2011 | 15.3 (0.35) | 23.1 (0.56) | 62.9 (0.72) |
| 2012 | 15.0 (0.34) | 23.1 (0.50) | 63.3 (0.63) |
| 2013 | 14.9 (0.40) | 24.1 (0.48) | 62.3 (0.68) |
| 2014 | 10.9 (0.29) | 25.6 (0.49) | 64.9 (0.59) |
| Non-Medicaid expansion states[5] | | | |
| 2009 | 20.0 (0.60) | 21.3 (0.54) | 60.1 (0.80) |
| 2010 | 20.3 (0.48) | 22.1 (0.51) | 59.0 (0.76) |
| 2011 | 19.6 (0.50) | 22.7 (0.50) | 59.1 (0.78) |
| 2012 | 19.2 (0.45) | 24.0 (0.55) | 58.3 (0.75) |
| 2013 | 18.4 (0.48) | 23.4 (0.51) | 59.6 (0.80) |
| 2014 | 16.0 (0.44) | 23.2 (0.52) | 62.1 (0.76) |
| 0–17 years | | | |
| Medicaid expansion states[4] | | | |
| 2009 | 5.9 (0.43) | 36.3 (1.09) | 59.5 (1.15) |
| 2010 | 6.7 (0.46) | 38.2 (1.05) | 56.5 (1.06) |
| 2011 | 5.9 (0.33) | 40.2 (1.11) | 55.4 (1.09) |
| 2012 | 5.3 (0.32) | 40.4 (1.00) | 55.9 (1.07) |
| 2013 | 5.6 (0.33) | 41.3 (0.86) | 54.5 (0.95) |
| 2014 | 4.3 (0.33) | 41.0 (0.84) | 56.2 (0.88) |
| Non-Medicaid expansion states[5] | | | |
| 2009 | 10.8 (0.68) | 39.4 (1.00) | 51.3 (1.20) |
| 2010 | 9.0 (0.47) | 41.7 (0.99) | 50.7 (1.08) |
| 2011 | 8.3 (0.46) | 42.0 (1.02) | 50.9 (1.11) |
| 2012 | 8.0 (0.46) | 43.9 (1.11) | 49.4 (1.07) |
| 2013 | 7.5 (0.40) | 43.1 (1.12) | 50.5 (1.23) |
| 2014 | 6.7 (0.43) | 43.5 (1.06) | 51.0 (1.11) |
| 18–64 years | | | |
| Medicaid expansion states[4] | | | |
| 2009 | 19.0 (0.43) | 14.7 (0.43) | 67.5 (0.63) |
| 2010 | 20.1 (0.47) | 15.5 (0.40) | 65.6 (0.62) |
| 2011 | 18.9 (0.41) | 16.6 (0.41) | 65.8 (0.61) |
| 2012 | 18.5 (0.39) | 16.7 (0.38) | 66.0 (0.53) |
| 2013 | 18.4 (0.49) | 17.7 (0.44) | 65.2 (0.65) |
| 2014 | 13.3 (0.34) | 19.9 (0.46) | 68.1 (0.56) |
| Non-Medicaid expansion states[5] | | | |
| 2009 | 23.6 (0.65) | 14.2 (0.44) | 63.6 (0.71) |
| 2010 | 24.8 (0.58) | 14.4 (0.45) | 62.2 (0.70) |
| 2011 | 24.1 (0.60) | 15.1 (0.42) | 62.3 (0.71) |
| 2012 | 23.7 (0.54) | 16.1 (0.44) | 61.8 (0.69) |
| 2013 | 22.7 (0.59) | 15.6 (0.41) | 63.2 (0.69) |
| 2014 | 19.6 (0.54) | 15.3 (0.41) | 66.5 (0.69) |

[1]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[2]Includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[3]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

[4]States moving forward with Medicaid expansion include AZ, AR, CA, CO, CT, DE, DC, HI, IL, IA, KY, MD, MA, MI, MN, NV, NJ, NM, NY, ND, OH, OR, RI, VT, WA, and WV (as of October 31, 2013).

[5]States not moving forward with Medicaid expansion include AL, AK, FL, GA, ID, IN, KS, LA, ME, MS, MO, MT, NE, NH, NC, OK, PA, SC, SD, TN, TX, UT, VA, WI, and WY (as of October 31, 2013).

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

DATA SOURCE: CDC/NCHS, National Health Interview Survey, 2009–2014, Family Core component.

**Table 13. Percentages of persons under age 65 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group, state Health Insurance Marketplace type, and year: United States, 2009–2014**

| Age group, state Health Insurance Marketplace type, and year | Uninsured[1] at the time of interview | Public health plan coverage[2] | Private health insurance coverage[3] |
|---|---|---|---|
| | Percent (standard error) | | |
| Under 65 years | | | |
| State-based Marketplace states[4] | | | |
| 2009 | 16.1 (0.52) | 20.7 (0.68) | 64.3 (0.89) |
| 2010 | 16.3 (0.46) | 21.6 (0.66) | 63.2 (0.80) |
| 2011 | 15.9 (0.46) | 23.6 (0.70) | 61.8 (0.88) |
| 2012 | 15.2 (0.43) | 24.2 (0.66) | 61.8 (0.83) |
| 2013 | 15.2 (0.48) | 25.0 (0.56) | 61.0 (0.83) |
| 2014 | 11.1 (0.38) | 26.4 (0.63) | 63.7 (0.78) |
| Partnership Marketplace states[5] | | | |
| 2009 | 14.1 (0.76) | 21.1 (1.39) | 66.7 (1.98) |
| 2010 | 14.7 (0.87) | 22.5 (1.15) | 64.8 (1.73) |
| 2011 | 14.3 (0.71) | 22.7 (1.28) | 64.5 (1.72) |
| 2012 | 14.1 (0.70) | 20.8 (1.12) | 66.7 (1.53) |
| 2013 | 14.2 (0.83) | 21.8 (1.07) | 65.6 (1.42) |
| 2014 | 10.2 (0.57) | 24.4 (1.06) | 67.2 (1.28) |
| Federally Facilitated Marketplace states[6] | | | |
| 2009 | 19.0 (0.53) | 21.2 (0.52) | 61.2 (0.74) |
| 2010 | 20.1 (0.48) | 22.1 (0.50) | 59.1 (0.70) |
| 2011 | 18.8 (0.45) | 22.6 (0.47) | 60.0 (0.71) |
| 2012 | 18.6 (0.41) | 23.6 (0.50) | 59.3 (0.67) |
| 2013 | 17.9 (0.44) | 23.3 (0.49) | 60.2 (0.74) |
| 2014 | 15.3 (0.40) | 23.3 (0.50) | 62.8 (0.69) |
| 0–17 years | | | |
| State-based Marketplace states[4] | | | |
| 2009 | 6.9 (0.61) | 36.5 (1.31) | 57.9 (1.31) |
| 2010 | 6.7 (0.50) | 38.0 (1.32) | 56.4 (1.31) |
| 2011 | 6.4 (0.47) | 40.9 (1.43) | 54.2 (1.39) |
| 2012 | 5.4 (0.43) | 42.2 (1.37) | 53.9 (1.46) |
| 2013 | 5.7 (0.37) | 42.8 (1.05) | 52.6 (1.18) |
| 2014 | 4.2 (0.40) | 42.0 (1.11) | 54.9 (1.13) |
| Partnership Marketplace states[5] | | | |
| 2009 | 3.1 (0.68) | 37.7 (2.78) | 62.0 (3.23) |
| 2010 | 4.1 (0.78) | 40.7 (2.21) | 57.9 (2.31) |
| 2011 | 4.2 (0.53) | 39.6 (2.44) | 58.0 (2.39) |
| 2012 | 3.6 (0.69) | 38.5 (2.20) | 59.9 (2.26) |
| 2013 | 4.2 (0.53) | 38.4 (1.95) | 59.2 (2.08) |
| 2014 | 3.2 (0.51) | 40.8 (1.88) | 58.4 (1.99) |
| Federally Facilitated Marketplace states[6] | | | |
| 2009 | 10.0 (0.60) | 38.5 (0.95) | 53.0 (1.13) |
| 2010 | 9.2 (0.48) | 40.7 (0.91) | 51.3 (0.97) |
| 2011 | 8.0 (0.40) | 41.4 (0.93) | 51.8 (1.01) |
| 2012 | 7.9 (0.41) | 42.7 (1.00) | 50.8 (0.98) |
| 2013 | 7.5 (0.39) | 42.6 (1.02) | 51.3 (1.11) |
| 2014 | 6.6 (0.41) | 42.6 (0.94) | 52.0 (1.00) |

See footnotes at end of table.

**Table 13. Percentages of persons under age 65 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age, state Health Insurance Marketplace type, and year: United States, 2009–2014 —*Continued***

| Age group, state Health Insurance Marketplace type, and year | Uninsured[1] at the time of interview | Public health plan coverage[2] | Private health insurance coverage[3] |
|---|---|---|---|
| | Percent (standard error) | | |
| 18–64 years | | | |
| State-based Marketplace states[4] | | | |
| 2009 | 19.6 (0.61) | 14.6 (0.53) | 66.8 (0.82) |
| 2010 | 19.9 (0.52) | 15.3 (0.48) | 65.9 (0.68) |
| 2011 | 19.5 (0.53) | 17.1 (0.52) | 64.7 (0.75) |
| 2012 | 18.8 (0.50) | 17.7 (0.49) | 64.7 (0.69) |
| 2013 | 18.7 (0.60) | 18.4 (0.52) | 64.1 (0.80) |
| 2014 | 13.6 (0.45) | 20.6 (0.57) | 67.0 (0.75) |
| Partnership Marketplace states[5] | | | |
| 2009 | 18.5 (0.97) | 14.5 (1.04) | 68.5 (1.70) |
| 2010 | 18.9 (1.12) | 15.3 (0.90) | 67.6 (1.59) |
| 2011 | 18.4 (0.92) | 15.9 (0.87) | 67.1 (1.52) |
| 2012 | 18.1 (0.85) | 13.9 (0.79) | 69.3 (1.36) |
| 2013 | 17.9 (0.98) | 15.7 (0.91) | 68.0 (1.29) |
| 2014 | 12.8 (0.68) | 18.2 (0.98) | 70.5 (1.22) |
| Federally Facilitated Marketplace states[6] | | | |
| 2009 | 22.6 (0.57) | 14.3 (0.41) | 64.5 (0.65) |
| 2010 | 24.5 (0.56) | 14.7 (0.43) | 62.2 (0.66) |
| 2011 | 23.0 (0.54) | 15.1 (0.39) | 63.3 (0.64) |
| 2012 | 22.8 (0.48) | 16.1 (0.41) | 62.7 (0.61) |
| 2013 | 22.0 (0.54) | 15.9 (0.41) | 63.6 (0.64) |
| 2014 | 18.6 (0.49) | 15.8 (0.41) | 66.9 (0.63) |

[1]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[2]Includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[3]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

[4]State-based Marketplace states are CA, CO, CT, DC, HI, ID, KY, MD, MA, MN, NV, NM, NY, OR, RI, VT, and WA (as of October 31, 2013).

[5]Partnership Marketplace states are AR, DE, IL, IA, MI, NH, and WV (as of October 31, 2013).

[6]Federally Facilitated Marketplace states are AL, AK, AZ, FL, GA, IN, KS, LA, ME, MS, MO, MT, NE, NJ, NC, ND, OH, OK, PA, SC, SD, TN, TX, UT, VA, WI, and WY (as of October 31, 2013).

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

DATA SOURCE: CDC/NCHS, National Health Interview Survey, 2009–2014, Family Core component.

**Table 14. Percentages of persons who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group and expanded region: United States, 2014**

| Age group and expanded region[1] | Uninsured[2] at the time of interview | Public health plan coverage[3] | Private health insurance coverage[4] |
|---|---|---|---|
| | Percent (standard error) | | |
| All ages | | | |
| All states | 11.5 (0.23) | 34.6 (0.37) | 61.8 (0.45) |
| New England | 5.3 (0.57) | 36.3 (1.64) | 68.5 (1.75) |
| Middle Atlantic | 8.6 (0.41) | 35.2 (0.83) | 65.3 (0.88) |
| East North Central | 9.0 (0.46) | 35.0 (0.91) | 66.6 (1.11) |
| West North Central | 8.8 (0.53) | 30.0 (1.18) | 71.0 (1.03) |
| South Atlantic | 14.0 (0.65) | 37.0 (0.89) | 56.2 (1.16) |
| East South Central | 11.2 (0.79) | 39.3 (2.01) | 58.3 (1.97) |
| West South Central | 18.0 (0.69) | 31.0 (1.09) | 56.6 (1.32) |
| Mountain | 12.6 (0.85) | 32.5 (1.69) | 62.3 (2.12) |
| Pacific | 11.3 (0.50) | 35.0 (0.88) | 59.0 (1.10) |
| Under 65 years | | | |
| All states | 13.3 (0.26) | 24.5 (0.36) | 63.6 (0.46) |
| New England | 6.3 (0.65) | 24.5 (1.79) | 70.4 (1.86) |
| Middle Atlantic | 10.1 (0.45) | 24.3 (0.77) | 66.8 (0.92) |
| East North Central | 10.5 (0.54) | 24.3 (0.95) | 67.0 (1.19) |
| West North Central | 10.1 (0.60) | 19.1 (0.86) | 72.4 (1.09) |
| South Atlantic | 16.5 (0.73) | 26.0 (0.88) | 58.6 (1.28) |
| East South Central | 13.1 (0.95) | 29.5 (2.18) | 59.6 (2.37) |
| West South Central | 20.3 (0.77) | 22.3 (0.89) | 58.5 (1.33) |
| Mountain | 14.5 (1.00) | 22.4 (1.60) | 64.6 (2.09) |
| Pacific | 12.7 (0.57) | 26.4 (0.90) | 61.9 (1.13) |
| 0–17 years | | | |
| All states | 5.5 (0.27) | 42.2 (0.65) | 53.7 (0.68) |
| New England | 2.4 (0.64) | 35.9 (3.16) | 63.2 (3.03) |
| Middle Atlantic | 3.7 (0.68) | 40.9 (1.65) | 56.4 (1.69) |
| East North Central | 3.5 (0.53) | 41.1 (1.52) | 57.9 (1.67) |
| West North Central | 3.7 (0.57) | 34.8 (1.71) | 64.3 (1.74) |
| South Atlantic | 5.5 (0.78) | 48.6 (1.60) | 46.2 (1.81) |
| East South Central | 5.1 (0.80) | 48.6 (3.24) | 47.8 (3.16) |
| West South Central | 10.5 (0.76) | 42.5 (1.91) | 48.2 (1.96) |
| Mountain | 7.9 (0.79) | 35.6 (2.88) | 58.4 (2.79) |
| Pacific | 4.8 (0.64) | 43.3 (1.57) | 52.7 (1.67) |

See footnotes at end of table.

**Table 14. Percentages of persons who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group and expanded region: United States, 2014—*Continued***

| Age group and expanded region[1] | Uninsured[2] at the time of interview | Public health plan coverage[3] | Private health insurance coverage[4] |
|---|---|---|---|
| | Percent (standard error) | | |
| 18–64 years | | | |
| All states | 16.3 (0.31) | 17.7 (0.32) | 67.3 (0.43) |
| New England | 7.6 (0.80) | 20.9 (1.63) | 72.7 (1.69) |
| Middle Atlantic | 12.3 (0.54) | 18.7 (0.91) | 70.4 (0.94) |
| East North Central | 13.1 (0.65) | 18.0 (0.84) | 70.4 (1.13) |
| West North Central | 12.6 (0.80) | 13.1 (0.80) | 75.5 (1.12) |
| South Atlantic | 20.6 (0.90) | 17.5 (0.79) | 63.2 (1.15) |
| East South Central | 16.1 (1.17) | 22.3 (1.85) | 64.0 (2.15) |
| West South Central | 24.4 (1.03) | 13.7 (0.67) | 62.9 (1.20) |
| Mountain | 17.5 (1.33) | 16.3 (1.23) | 67.5 (1.92) |
| Pacific | 15.8 (0.64) | 19.9 (0.78) | 65.4 (1.04) |

[1]The *New England* region includes CT, ME, MA, NH, RI, and VT. The *Middle Atlantic* region includes DE, DC, MD, NJ, NY, and PA. The *East North Central* region includes IL, IN, MI, OH, and WI. The *West North Central* region includes IA, KS, MN, MO, NE, ND, and SD. The *South Atlantic* region includes FL, GA, NC, SC, VA, and WV. The *East South Central* region includes AL, KY, MS, and TN. The *West South Central* region includes AR, LA, OK, and TX. The *Mountain* region includes AZ, CO, ID, MT, NV, NM, UT, and WY. The *Pacific* region includes AK, CA, HI, OR, and WA.

[2]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[3]Includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[4]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

DATA SOURCE: CDC/NCHS, National Health Interview Survey, 2014, Family Core component.

**Table 15. Percentages of persons in states who lacked health insurance coverage, had public health plan coverage, or had private health insurance coverage at the time of interview, by age group: United States, 2014**

| Age group and selected states[1] | Uninsured[2] at the time of interview | Public health plan coverage[3] | Private health insurance coverage[4] |
|---|---|---|---|
| | Percent (standard error) | | |
| All ages | | | |
| All states[5] | 11.5 (0.20) | 34.6 (0.33) | 61.8 (0.38) |
| Alabama | 9.8 (1.48) | 38.7 (2.68) | 62.0 (3.02) |
| Alaska | 19.4 (1.99) | 28.6 (2.52) | 58.9 (3.09) |
| Arizona | 14.6 (1.50) | 38.2 (2.30) | 52.9 (2.66) |
| Arkansas | 10.9 (1.56) | 36.6 (2.67) | 61.6 (3.04) |
| California | 12.0 (0.51) | 34.9 (0.88) | 57.5 (1.09) |
| Colorado | 9.5 (1.28) | 27.5 (2.16) | 70.7 (2.49) |
| Connecticut | 7.0 (1.25) | 35.9 (2.60) | 64.1 (2.94) |
| Delaware | 4.4 (1.01) | 38.2 (2.65) | 68.5 (2.86) |
| District of Columbia | 3.0 (0.87) | 39.7 (2.78) | 64.3 (3.07) |
| Florida | 15.3 (1.00) | 39.4 (1.61) | 51.8 (1.31) |
| Georgia | 14.2 (1.44) | 33.5 (1.32) | 58.1 (1.80) |
| Hawaii | *2.0 (0.69) | 43.9 (2.73) | 69.2 (2.86) |
| Idaho | 13.3 (1.51) | 29.6 (2.25) | 66.5 (2.63) |
| Illinois | 10.3 (0.96) | 34.2 (1.57) | 66.0 (1.77) |
| Indiana | 12.0 (1.41) | 32.7 (2.25) | 64.7 (2.59) |
| Iowa | 5.6 (0.96) | 29.3 (2.10) | 75.0 (2.26) |
| Kansas | 9.0 (1.16) | 33.1 (2.12) | 70.1 (2.33) |
| Kentucky | 10.9 (1.35) | 43.8 (2.38) | 53.0 (2.70) |
| Louisianna | 12.9 (1.49) | 38.1 (2.39) | 55.9 (2.76) |
| Maine | 11.3 (1.42) | 36.9 (2.40) | 60.9 (2.74) |
| Maryland | 7.9 (1.27) | 34.6 (2.48) | 67.1 (2.77) |
| Massachusetts | 2.6 (0.72) | 38.7 (2.46) | 71.0 (2.59) |
| Michigan | 8.0 (0.99) | 35.5 (1.96) | 67.7 (2.44) |
| Minnesota | 5.7 (1.06) | 27.4 (2.26) | 76.3 (2.43) |
| Mississippi | 14.9 (1.66) | 38.5 (2.52) | 56.4 (2.90) |
| Missouri | 12.4 (1.53) | 30.9 (2.38) | 65.3 (2.77) |
| Montana | 11.2 (1.60) | 42.0 (2.77) | 61.5 (3.09) |
| Nebraska | 11.2 (1.40) | 31.1 (2.28) | 66.4 (2.62) |
| Nevada | 15.0 (1.58) | 32.8 (2.31) | 57.8 (2.75) |
| New Hampshire | 8.0 (1.26) | 28.8 (2.33) | 74.5 (2.54) |
| New Jersey | 9.4 (1.13) | 27.1 (1.90) | 72.9 (2.15) |
| New Mexico | 11.3 (1.49) | 49.5 (2.61) | 49.2 (2.95) |
| New York | 9.4 (0.77) | 39.9 (1.41) | 57.5 (1.60) |
| North Carolina | 14.8 (1.17) | 38.0 (1.73) | 54.9 (2.61) |
| North Dakota | 6.0 (1.13) | 27.0 (2.34) | 79.4 (2.41) |
| Ohio | 7.6 (0.65) | 37.3 (1.70) | 64.6 (1.87) |
| Oklahoma | 18.1 (1.64) | 39.1 (2.30) | 50.0 (2.66) |
| Oregon | 8.8 (1.29) | 41.0 (2.50) | 58.8 (2.82) |
| Pennsylvania | 7.9 (0.84) | 34.2 (1.92) | 69.8 (1.58) |
| Rhode Island | 6.4 (1.13) | 31.2 (2.36) | 70.2 (2.63) |
| South Carolina | 14.5 (1.71) | 39.7 (2.64) | 53.5 (3.04) |
| South Dakota | 8.5 (1.27) | 31.5 (2.35) | 72.4 (2.55) |
| Tennessee | 10.8 (1.42) | 36.9 (2.44) | 60.1 (2.80) |
| Texas | 19.4 (0.76) | 28.3 (0.99) | 57.2 (1.31) |
| Utah | 12.9 (1.32) | 22.4 (1.82) | 73.1 (2.19) |
| Vermont | 8.6 (1.49) | 33.6 (2.79) | 66.8 (3.14) |
| Virginia | 10.8 (1.30) | 31.3 (2.15) | 67.0 (2.46) |
| Washington | 9.8 (1.24) | 31.7 (2.15) | 66.0 (2.47) |
| West Virginia | 7.6 (1.21) | 43.0 (2.50) | 59.6 (2.80) |
| Wisconsin | 6.3 (1.17) | 33.7 (2.53) | 73.5 (2.67) |
| Wyoming | 10.9 (1.49) | 20.9 (2.16) | 75.3 (2.59) |

See footnotes at end of table.

**Table 15. Percentages of persons in states who lacked health insurance coverage, had public health plan coverage, or had private health insurance coverage at the time of interview, by age group: United States, 2014 —*Continued***

| Age group and selected states[1] | Uninsured[2] at the time of interview | Public health plan coverage[3] | Private health insurance coverage[4] |
|---|---|---|---|
| | Percent (standard error) | | |
| Under 65 years | | | |
| All states[5] | 13.3 (0.22) | 24.5 (0.33) | 63.6 (0.41) |
| Alabama | 11.8 (1.74) | 28.0 (2.77) | 63.4 (3.38) |
| Alaska | 21.2 (2.19) | 22.2 (2.54) | 58.6 (3.43) |
| Arizona | 16.9 (1.70) | 28.7 (2.34) | 55.9 (2.93) |
| Arkansas | 12.7 (1.80) | 25.9 (2.71) | 62.7 (3.41) |
| California | 13.4 (0.56) | 26.8 (0.93) | 60.6 (1.18) |
| Colorado | 10.7 (1.42) | 18.4 (2.04) | 71.8 (2.70) |
| Connecticut | 8.0 (1.42) | 25.6 (2.62) | 67.2 (3.21) |
| Delaware | 5.4 (1.21) | 25.7 (2.68) | 70.6 (3.18) |
| District of Columbia | 3.3 (0.98) | 32.4 (2.92) | 64.7 (3.40) |
| Florida | 18.8 (1.11) | 26.0 (1.41) | 55.9 (1.47) |
| Georgia | 16.1 (1.65) | 24.7 (1.41) | 59.8 (2.05) |
| Hawaii | *2.5 (0.87) | 26.1 (2.81) | 72.8 (3.24) |
| Idaho | 15.2 (1.72) | 19.7 (2.18) | 66.6 (2.94) |
| Illinois | 12.0 (1.13) | 24.3 (1.79) | 65.5 (1.92) |
| Indiana | 13.8 (1.60) | 22.9 (2.23) | 64.5 (2.89) |
| Iowa | 6.4 (1.10) | 18.8 (2.00) | 76.4 (2.47) |
| Kansas | 10.8 (1.37) | 19.5 (2.00) | 71.8 (2.59) |
| Kentucky | 12.5 (1.53) | 36.0 (2.53) | 53.3 (3.00) |
| Louisianna | 15.2 (1.73) | 27.5 (2.46) | 58.4 (3.09) |
| Maine | 13.8 (1.72) | 24.2 (2.44) | 63.9 (3.12) |
| Maryland | 9.3 (1.46) | 24.8 (2.47) | 67.3 (3.06) |
| Massachusetts | 3.2 (0.87) | 25.8 (2.47) | 72.2 (2.88) |
| Michigan | 9.3 (1.12) | 25.0 (1.99) | 67.5 (2.70) |
| Minnesota | 6.5 (1.19) | 18.6 (2.14) | 76.7 (2.65) |
| Mississippi | 18.0 (1.95) | 26.2 (2.55) | 57.9 (3.27) |
| Missouri | 14.2 (1.75) | 20.0 (2.29) | 67.2 (3.07) |
| Montana | 14.6 (2.01) | 24.9 (2.82) | 63.5 (3.58) |
| Nebraska | 12.8 (1.63) | 20.8 (2.25) | 67.6 (2.96) |
| Nevada | 17.6 (1.82) | 21.3 (2.24) | 63.1 (3.01) |
| New Hampshire | 9.5 (1.52) | 14.9 (2.11) | 76.9 (2.84) |
| New Jersey | 10.8 (1.28) | 15.8 (1.71) | 74.4 (2.34) |
| New Mexico | 14.0 (1.82) | 37.4 (2.89) | 50.5 (3.41) |
| New York | 11.0 (0.89) | 30.3 (1.47) | 60.0 (1.77) |
| North Carolina | 17.3 (1.30) | 28.2 (1.98) | 56.2 (2.93) |
| North Dakota | 7.3 (1.35) | 10.6 (1.82) | 84.1 (2.47) |
| Ohio | 8.9 (0.78) | 26.3 (1.86) | 66.6 (2.06) |
| Oklahoma | 21.5 (1.91) | 28.3 (2.39) | 52.0 (3.02) |
| Oregon | 10.7 (1.56) | 28.5 (2.60) | 62.3 (3.18) |
| Pennsylvania | 9.5 (1.02) | 21.0 (1.48) | 70.8 (1.83) |
| Rhode Island | 7.4 (1.28) | 22.1 (2.32) | 73.1 (2.82) |
| South Carolina | 17.1 (1.97) | 29.3 (2.72) | 54.4 (3.40) |
| South Dakota | 10.4 (1.50) | 17.9 (2.15) | 72.7 (2.85) |
| Tennessee | 12.5 (1.61) | 27.3 (2.48) | 62.1 (3.08) |
| Texas | 21.5 (0.83) | 20.4 (0.87) | 59.0 (1.38) |
| Utah | 14.4 (1.46) | 13.2 (1.61) | 74.6 (2.36) |
| Vermont | 9.8 (1.74) | 25.6 (2.91) | 65.3 (3.62) |
| Virginia | 12.5 (1.49) | 20.7 (2.08) | 68.3 (2.73) |
| Washington | 10.9 (1.37) | 23.3 (2.12) | 67.3 (2.68) |
| West Virginia | 9.0 (1.42) | 33.4 (2.67) | 59.9 (3.17) |
| Wisconsin | 7.5 (1.39) | 20.4 (2.42) | 74.7 (2.98) |
| Wyoming | 11.9 (1.64) | 13.5 (1.97) | 76.3 (2.80) |

See footnotes at end of table.

**Table 15. Percentages of persons in states who lacked health insurance coverage, had public health plan coverage, or had private health insurance coverage at the time of interview, by age group: United States, 2014 —*Continued***

| Age group and selected states[1] | Uninsured[2] at the time of interview | Public health plan coverage[3] | Private health insurance coverage[4] |
|---|---|---|---|
| | Percent (standard error) | | |
| 18–64 years | | | |
| All states[5] | 16.3 (0.26) | 17.7 (0.29) | 67.3 (0.37) |
| Alabama | 14.8 (2.05) | 20.7 (2.46) | 68.3 (3.10) |
| Alaska | 24.6 (1.69) | 14.2 (2.05) | 63.3 (3.11) |
| Arizona | 19.5 (1.01) | 22.4 (2.22) | 59.4 (2.87) |
| Arkansas | 15.6 (2.50) | 17.7 (2.31) | 68.0 (3.10) |
| California | 16.7 (0.67) | 20.4 (0.77) | 63.9 (1.10) |
| Colorado | 13.3 (1.43) | 12.3 (1.74) | 75.1 (2.52) |
| Connecticut | 10.0 (2.55) | 20.5 (2.35) | 70.3 (2.91) |
| Delaware | *6.0 (2.23) | 20.2 (2.35) | 74.8 (2.79) |
| District of Columbia | † | 27.1 (2.63) | 69.6 (2.99) |
| Florida | 23.0 (1.34) | 16.9 (1.20) | 61.0 (1.32) |
| Georgia | 20.2 (2.21) | 16.5 (1.28) | 64.3 (1.96) |
| Hawaii | † | 22.0 (2.56) | 76.2 (2.89) |
| Idaho | 21.9 (1.81) | 10.4 (1.71) | 68.9 (2.84) |
| Illinois | 15.0 (1.26) | 17.4 (1.49) | 69.2 (1.78) |
| Indiana | 18.3 (2.09) | 13.9 (1.84) | 68.8 (2.70) |
| Iowa | 8.4 (1.51) | 13.1 (1.71) | 79.2 (2.26) |
| Kansas | 13.9 (1.87) | 12.8 (1.71) | 75.0 (2.43) |
| Kentucky | 15.6 (2.00) | 29.5 (2.35) | 56.6 (2.80) |
| Louisianna | 18.9 (2.16) | 20.0 (2.14) | 62.1 (2.85) |
| Maine | 16.9 (0.95) | 18.4 (2.11) | 66.1 (2.82) |
| Maryland | 12.3 (2.13) | 18.7 (2.23) | 70.9 (2.85) |
| Massachusetts | *3.8 (1.84) | 23.7 (2.32) | 73.8 (2.63) |
| Michigan | 11.6 (1.30) | 19.9 (1.82) | 69.8 (2.61) |
| Minnesota | 8.0 (1.52) | 13.5 (1.86) | 79.4 (2.42) |
| Mississippi | 22.4 (1.57) | 17.0 (2.14) | 63.0 (3.02) |
| Missouri | 16.9 (1.97) | 14.0 (1.94) | 70.4 (2.80) |
| Montana | 18.0 (1.81) | 19.9 (2.55) | 64.8 (3.35) |
| Nebraska | 16.9 (2.14) | 10.4 (1.69) | 73.9 (2.67) |
| Nevada | 20.4 (1.86) | 15.0 (1.94) | 66.4 (2.81) |
| New Hampshire | 11.6 (2.07) | 9.4 (1.63) | 80.5 (2.43) |
| New Jersey | 12.9 (1.44) | 11.9 (1.47) | 76.3 (2.12) |
| New Mexico | 18.7 (2.36) | 27.6 (2.65) | 55.7 (3.22) |
| New York | 12.9 (0.90) | 25.1 (1.42) | 63.3 (1.72) |
| North Carolina | 22.5 (1.84) | 16.9 (1.70) | 62.5 (2.69) |
| North Dakota | 9.3 (1.92) | 8.7 (1.61) | 83.7 (2.31) |
| Ohio | 10.9 (0.91) | 21.3 (1.52) | 69.6 (1.87) |
| Oklahoma | 26.6 (1.78) | 19.2 (2.09) | 55.8 (2.88) |
| Oregon | 13.3 (2.00) | 21.3 (2.28) | 67.1 (2.87) |
| Pennsylvania | 11.9 (1.20) | 13.8 (1.45) | 75.6 (1.73) |
| Rhode Island | 9.0 (1.75) | 18.3 (2.13) | 74.7 (2.63) |
| South Carolina | 21.0 (2.03) | 22.9 (2.43) | 57.7 (3.13) |
| South Dakota | 13.4 (1.32) | 11.9 (1.81) | 75.8 (2.63) |
| Tennessee | 14.8 (2.10) | 20.5 (2.22) | 66.8 (2.84) |
| Texas | 25.7 (1.03) | 11.7 (0.66) | 63.5 (1.19) |
| Utah | 16.2 (1.78) | 10.5 (1.51) | 75.0 (2.35) |
| Vermont | 9.1 (1.24) | 21.1 (2.64) | 70.0 (3.25) |
| Virginia | 15.2 (1.66) | 15.6 (1.81) | 70.9 (2.49) |
| Washington | 13.3 (1.77) | 16.7 (1.86) | 71.2 (2.47) |
| West Virginia | 12.2 (2.05) | 27.8 (2.47) | 62.7 (2.92) |
| Wisconsin | 8.7 (1.91) | 14.1 (2.04) | 78.4 (2.65) |
| Wyoming | 15.2 (1.63) | 10.0 (1.71) | 76.3 (2.66) |

See footnotes at end of table.

**Table 15. Percentages of persons in states who lacked health insurance coverage, had public health plan coverage, or had private health insurance coverage at the time of interview, by age group: United States, 2014 —*Continued***

| Age group and selected states[1] | Uninsured[2] at the time of interview | Public health plan coverage[3] | Private health insurance coverage[4] |
|---|---|---|---|
| | Percent (standard error) | | |
| 0–17 years | | | |
| All states | 5.5 (0.23) | 42.2 (0.61) | 53.7 (0.65) |
| Alabama | *3.8 (1.68) | 47.2 (5.24) | 50.5 (5.36) |
| Arizona | 11.2 (2.13) | 42.1 (3.98) | 48.6 (4.11) |
| California | 5.0 (0.58) | 43.3 (1.69) | 52.3 (1.70) |
| Colorado | *4.2 (1.44) | 33.1 (4.01) | 63.8 (4.18) |
| Florida | 6.6 (1.03) | 52.3 (2.62) | 41.4 (2.56) |
| Georgia | 5.5 (0.94) | 45.9 (2.99) | 48.3 (2.95) |
| Idaho | *3.5 (1.33) | 36.1 (4.14) | 62.6 (4.26) |
| Illinois | *3.6 (1.26) | 43.2 (3.30) | 55.1 (3.15) |
| Indiana | 3.3 (1.31) | 43.9 (4.31) | 54.5 (4.41) |
| Iowa | 1.7 (0.92) | 32.5 (4.01) | 69.8 (4.01) |
| Kansas | 4.5 (1.40) | 33.5 (3.82) | 64.8 (3.94) |
| Kentucky | 4.1 (1.52) | 53.6 (4.57) | 44.3 (4.65) |
| Louisianna | 4.5 (1.69) | 49.5 (4.86) | 47.8 (4.96) |
| Maine | 3.7 (1.67) | 42.9 (5.26) | 56.8 (5.37) |
| Maryland | 1.9 (1.08) | 39.6 (4.65) | 58.7 (4.78) |
| Massachusetts | 1.3 (0.96) | 32.6 (4.78) | 67.3 (4.88) |
| Michigan | 3.3 (1.06) | 38.2 (3.46) | 61.3 (4.01) |
| Minnesota | 2.6 (1.25) | 31.8 (4.31) | 69.8 (4.34) |
| Mississippi | 5.6 (1.92) | 52.2 (4.98) | 43.7 (5.05) |
| Missouri | 6.0 (2.01) | 38.3 (4.90) | 57.2 (5.09) |
| Nebraska | *3.5 (1.41) | 44.6 (4.57) | 53.2 (4.68) |
| Nevada | 10.1 (2.33) | 37.9 (4.46) | 54.1 (4.68) |
| New Jersey | *4.3 (1.43) | 27.9 (3.77) | 68.5 (3.99) |
| New Mexico | *3.3 (1.51) | 60.0 (4.94) | 38.5 (5.01) |
| New York | 5.1 (1.38) | 46.4 (2.62) | 49.5 (2.85) |
| North Carolina | 5.6 (1.18) | 53.7 (3.61) | 41.9 (3.83) |
| Ohio | *3.4 (1.10) | 40.3 (3.65) | 58.1 (3.45) |
| Oklahoma | 10.1 (2.22) | 48.5 (4.37) | 43.7 (4.43) |
| Oregon | *3.0 (1.49) | 49.7 (5.19) | 48.2 (5.30) |
| Pennsylvania | *2.4 (0.97) | 42.3 (3.16) | 56.5 (3.18) |
| Rhode Island | *3.2 (1.40) | 31.7 (4.41) | 68.9 (4.48) |
| South Dakota | *2.9 (1.31) | 32.9 (4.36) | 64.9 (4.52) |
| Tennessee | *6.4 (1.94) | 44.8 (4.70) | 49.9 (4.82) |
| Texas | 11.7 (0.93) | 40.5 (2.12) | 48.8 (2.24) |
| Utah | 11.1 (1.91) | 18.2 (2.79) | 73.8 (3.25) |
| Virginia | *4.4 (1.58) | 36.0 (4.38) | 60.6 (4.55) |
| Washington | *4.3 (1.43) | 41.2 (4.13) | 56.5 (4.25) |
| West Virginia | † | 47.7 (4.99) | 52.9 (5.09) |
| Wisconsin | *4.0 (1.71) | 38.7 (5.09) | 63.6 (5.13) |
| Wyoming | *4.9 (1.79) | 20.8 (3.99) | 76.1 (4.28) |

* Estimate has a relative standard error (RSE) greater than 30% and less than or equal to 50% and should be used with caution as it does not meet standards of reliability or precision.

†Estimate has an RSE of greater than 50% and is not shown.

[1]Estimates are presented for fewer than 50 states and the District of Columbia for children aged 0–17 due to considerations of sample size and precision.

[2]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[3]Includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[4]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, or purchased through local or community programs. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

[5]Includes all 50 states and the District of Columbia.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

DATA SOURCE: CDC/NCHS, National Health Interview Survey, 2014, Family Core component.

## Technical Notes

The Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics (NCHS) is releasing selected estimates of health insurance coverage for the civilian noninstitutionalized U.S. population based on data from the 2014 National Health Interview Survey (NHIS), along with comparable estimates from the 2009–2013 NHIS.

To reflect different policy-relevant perspectives, three measures of lack of health insurance coverage are provided: (a) uninsured at the time of interview, (b) uninsured at least part of the year prior to interview (which also includes persons uninsured for more than a year), and (c) uninsured for more than a year at the time of interview. The three time frames are defined as:

- *Uninsured at the time of interview* provides an estimate of persons who at any given time may have experienced barriers to obtaining needed health care.
- *Uninsured at any time in the year prior to interview* provides an annual caseload of persons who may experience barriers to obtaining needed health care. This measure includes persons who have insurance at the time of interview but who had a period of noncoverage in the year prior to interview, as well as those who are currently uninsured and who may have been uninsured for a long period of time.
- *Uninsured for more than a year* provides an estimate of those with a persistent lack of coverage who may be at high risk of not obtaining preventive services or care for illness and injury.

These three measures are not mutually exclusive, and a given individual may be counted in more than one of the measures. Estimates of enrollment in public and private coverage are also provided.

This report also includes estimates for three types of consumer-directed private health care. Consumer-directed health care may enable individuals to have more control over when and how they access care, what types of care they use, and how much they spend on health care services. National attention to consumer-directed health care increased following enactment of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (P.L. 108–173), which established tax-advantaged health savings accounts (HSAs) (1). In 2007, three new questions were added to the health insurance section of NHIS to monitor enrollment in consumer-directed health care among persons with private health insurance. Estimates are provided for enrollment in high-deductible health plans (HDHPs), plans with high deductibles coupled with HSAs (i.e., consumer-directed health plans or CDHPs), and being in a family with a flexible spending account (FSA) for medical expenses not otherwise covered. For a more complete description of consumer-directed health care, see "Definitions of selected terms" below.

The 2014 health insurance estimates are being released prior to final data editing and final weighting, to provide access to the most recent information from NHIS. Differences between estimates calculated using preliminary data files and final data files are typically less than 0.1 percentage point. However, preliminary estimates of persons without health insurance coverage are generally 0.1–0.3 percentage points lower than the final estimates due to the editing procedures used for the final data files.

Estimates for 2014 are stratified by age group, sex, race/ethnicity, poverty status, marital status, employment status, region, and educational attainment.

### Data source

NHIS is a multistage probability sample survey of the civilian noninstitutionalized population of the United States and is the source of data for this report. The survey is conducted continuously throughout the year by NCHS through an agreement with the U.S. Census Bureau.

NHIS is a comprehensive health survey that can be used to relate health insurance coverage to health outcomes and health care utilization. It has a low item nonresponse rate (about 1%) for the health insurance questions. Because NHIS is conducted throughout the year—yielding a nationally representative sample each month—data can be analyzed monthly or quarterly to monitor health insurance coverage trends.

The fundamental structure of the current NHIS oversamples Hispanic, black, and Asian populations. Visit the NCHS website at: http://www.cdc.gov/nchs/nhis.htm for more information on the design, content, and use of NHIS.

The data for this report are derived from the Family Core component of the 2009–2014 NHIS, which collects information on all family members in each household. Data analyses for the 2014 NHIS were based on 111,682 persons in the Family Core.

Data on health insurance status were edited using an automated system based on logic checks and keyword searches. Information from follow-up questions, such as plan name(s), were used to reassign insurance status and type of coverage to avoid misclassification. For comparability, the estimates for all years were created using these same procedures. The analyses excluded persons with unknown health insurance status (about 1% of respondents each year).

### Estimation procedures

NCHS creates survey weights for each calendar quarter of the NHIS sample. The NHIS data weighting procedure is described in more detail at: http://www.cdc.gov/nchs/data/series/sr_02/sr02_165.pdf. Estimates were calculated using NHIS survey weights, which are calibrated to census totals for sex, age, and race/ethnicity of the U.S. civilian noninstitutionalized population. Weights for 2009–2011 were derived from 2000 census-based population estimates. Beginning with 2012 NHIS data, weights were derived from 2010 census-based population estimates.

Point estimates and estimates of their variances were calculated using SUDAAN software (RTI International, Research Triangle Park, N.C.) to account for the complex sample design of NHIS, taking into account stratum and primary sampling unit (PSU) identifiers. The

Taylor series linearization method was chosen for variance estimation.

Trends in coverage were generally assessed using Joinpoint regression (2), which characterizes trends as joined linear segments. A Joinpoint is the year where two segments with different slopes meet. Joinpoint software uses statistical criteria to determine the fewest number of segments necessary to characterize a trend and the year(s) when segments begin and end. Trends from 2010 to 2014 were also evaluated using logistic regression analysis.

State-specific health insurance estimates are presented for all 50 states and the District of Columbia for persons of all ages, persons under age 65, and adults aged 18–64. State-specific estimates are presented for 40 states for children aged 0–17. Estimates are not presented for all 50 states and the District of Columbia for children due to considerations of sample size and precision. All states had at least 1,000 interviews for persons of all ages. Estimates for children in states that did not have at least 300 children with completed interviews are not presented.

For the 10 states with the largest populations (California, Florida, Georgia, Illinois, Michigan, New York, North Carolina, Ohio, Pennsylvania, and Texas), standard errors (SEs) were calculated using SUDAAN. Because of small sample sizes and limitations in the NHIS design, similarly estimated SEs for other states could be statistically unstable or negatively biased; consequently, for states other than the largest 10 states, an estimated design effect was used to calculate SEs. For this report, the design effect, *deff*, of a percentage is the ratio of the sampling variance of the percentage (taking into account the complex NHIS sample design) to the sampling variance of the percentage from a simple random sample (SRS) based on the same observed number of persons.

Therefore, for each health insurance measure and domain, SEs for smaller states were calculated by multiplying the SRS SE by $A$, where $A$ is the average value of the square root of *deff* over the 10 most populous states. Values of $A$ ranged from 1.55 for children who were uninsured to 2.30 for persons under 65 with private coverage.

Calculation of SEs of the differences between state and expanded regional estimates and national estimates accounted for correlations.

Unless otherwise noted, all estimates shown meet the NCHS standard of having less than or equal to 30% relative standard error. Differences between percentages or rates were evaluated using two-sided significance tests at the 0.05 level. All differences discussed are significant unless otherwise noted. Lack of comment regarding the difference between any two estimates does not necessarily mean that the difference was tested and found to be not significant.

## Definitions of selected terms

**Private health insurance coverage—**Includes persons who had any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care.

**Public health plan coverage—**Includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plans, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

**Uninsured—**A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, CHIP, state-sponsored or other government-sponsored health plan, or military plan at the time of interview. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

**Directly purchased coverage**—Private insurance that was originally obtained through direct purchase or other means not related to employment.

**Employment-based coverage**—Private insurance that was originally obtained through a present or former employer or union or a professional association.

**Exchange-based coverage**—A private health insurance plan purchased through the Health Insurance Marketplace or state-based exchanges that were established as part of the Affordable Care Act (ACA). of 2010 (P.L. 111–148, P.L. 111–152) In response to ACA, several new questions were added to NHIS to capture health care plans obtained through exchange-based coverage.

In general, if a family member is reported to have coverage through the exchange, that report is considered accurate unless there is other information (e.g., plan name or information about premiums) that clearly contradicts that report. Similarly, if a family member is not reported to have coverage through the exchange, that report is considered accurate unless there is other information that clearly contradicts that report. For a more complete discussion of the procedures used in the classification of exchange-based coverage, see http://www.cdc.gov/nchs/nhis/insurance.htm.

Based on these classification procedures, an average of 2.2% (SE, 0.10) of persons under age 65, 2.7% (SE, 0.11) of adults aged 18–64, 0.9% (SE, 0.11) of children under age 18, and 1.9% (SE, 0.17) of adults aged 19–25, had exchange-based private health insurance coverage in 2014. This equates to 5.9 million persons under age 65 and 5.2 million adults aged 18–64, 0.7 million children, and 0.6 million adults aged 19–25. If these procedures had not been used and reports of coverage through the exchanges (or lack thereof) had been taken at face value, the estimate would have been higher. For example, an average of 3.0% (7.9 million) of persons under age 65 would have been reported to have obtained their coverage through exchanges over the full year of 2014.

**High-deductible health plan (HDHP)**—For persons with private health insurance, a question was asked regarding the annual deductible of each private health insurance plan. An HDHP was defined in 2013 and 2014 as a private health plan with an annual

deductible of at least $1,250 for self-only coverage or $2,500 for family coverage. The deductible is adjusted annually for inflation. For 2010 through 2012, the annual deductible for self-only coverage was $1,200 and for family coverage was $2,400. For 2009, the annual deductible for self-only coverage was $1,150 and for family coverage was $2,300.

**Consumer-directed health plan (CDHP)**—Defined as an HDHP with a special account to pay for medical expenses. Unspent funds are carried over to subsequent years. For plans considered to be HDHPs, a follow-up question was asked regarding these special accounts. A person is considered to have a CDHP if there was a "yes" response to the following question: *With this plan, is there a special account or fund that can be used to pay for medical expenses? The accounts are sometimes referred to as Health Savings Accounts (HSAs), Health Reimbursement Accounts (HRAs), Personal Care accounts, Personal Medical funds, or Choice funds, and are different from Flexible Spending Accounts*.

**Health savings account (HSA)**—A tax-advantaged account or fund that can be used to pay for medical expenses. It must be coupled with an HDHP. The funds contributed to the account are not subject to federal income tax at the time of deposit. Unlike FSAs, HSA funds roll over and accumulate year to year if not spent. HSAs are owned by the individual. Funds may be used to pay for qualified medical expenses at any time without federal tax liability. HSAs may also be referred to as Health Reimbursement Accounts (HRAs), Personal Care accounts, Personal Medical funds, or Choice funds, and the term "HSA" in this report includes accounts that use these alternative names.

**Flexible spending account (FSA) for medical expenses**—A person is considered to be in a family with an FSA if there was a "yes" response to the following question: *[Do you/Does anyone in your family] have a Flexible Spending Account for health expenses? These accounts are offered by some employers to allow employees to set aside pretax dollars of their own money for their use throughout the year to reimburse themselves for their out-of-pocket expenses for health care. With this type of account, any money remaining in the account at the end of the year, following a short grace period, is lost to the employee.*

The measures of HDHP enrollment, CDHP enrollment, and being in a family with an FSA for medical expenses are not mutually exclusive; a person may be counted in more than one measure.

**Medicaid expansion status**—Under provisions of the Affordable Care Act (ACA) of 2010 (P.L. 111–148, P.L. 111–152), states have the option to expand Medicaid eligibility to cover adults who have income up to and including 138% of the federal poverty level. There is no deadline for states to choose to implement the Medicaid expansion, and they may do so at any time. As of October 31, 2013, 26 states and the District of Columbia are moving forward with Medicaid expansion.

**Health Insurance Marketplace**—A resource where individuals, families, and small businesses can learn about their health coverage options; compare health insurance plans based on cost, benefits, and other important features; choose a plan; and enroll in coverage. The marketplace also provides information on programs that help people with low-to-moderate income and resources pay for coverage. There are three types of Health Insurance Marketplaces: (a) a State-based Marketplace set up and operated solely by the state; (b) a hybrid Partnership Marketplace in which the state runs certain functions and makes key decisions and may tailor the marketplace to local needs and market conditions, but which is operated by the federal government; and (c) the Federally Facilitated Marketplace operated solely by the federal government.

**Education**—The categories of education are based on the years of school completed or highest degree obtained for persons aged 18 and over.

**Employment**—Employment status is assessed at the time of interview and is obtained for persons aged 18 and over. In this release, it is presented only for persons aged 18–64.

**Hispanic or Latino origin and race**—Hispanic or Latino origin and race are two separate and distinct categories. Persons of Hispanic or Latino origin may be of any race or combination of races. Hispanic or Latino origin includes persons of Mexican, Puerto Rican, Cuban, Central and South American, or Spanish origin. Race is based on the family respondent's description of his or her own race background, as well as the race background of other family members. More than one race may be reported for a person. For conciseness, the text, tables, and figures in this report use shorter versions of the 1997 Office of Management and Budget (OMB) terms for race and Hispanic or Latino origin. For example, the category "Not Hispanic or Latino, black or African American, single race" is referred to as "non-Hispanic black, single race" in the text, tables, and figures. Estimates for non-Hispanic persons of races other than white only, black only, and Asian only, or of multiple races, are combined into the "Other races and multiple races" category.

**Poverty status**—Poverty categories are based on the ratio of the family's income in the previous calendar year to the appropriate poverty threshold (given the family's size and number of children) defined by the U.S. Census Bureau for that year (3–8). Persons categorized as "Poor" have a ratio less than 1.0 (i.e., their family income was below the poverty threshold); "Near-poor" persons have incomes of 100% to less than 200% of the poverty threshold; and "Not-poor" persons have incomes that are 200% of the poverty threshold or greater. The remaining group of respondents is coded as "Unknown" with respect to poverty status. The percentage of respondents with unknown poverty status (12.3% in 2009, 12.2% in 2010, 11.5% in 2011, 11.4% in 2012, 10.2% in 2013, and 8.8% in 2014) is disaggregated by age and insurance status in Tables 4, 5, and 6.

For more information on unknown income and unknown poverty status, see the NHIS Survey Description document for 2009–2013 (available from: http://www.cdc.gov/nchs/nhis/quest_data_related_1997_forward.htm).

NCHS imputes income for approximately 30% of NHIS records. The imputed income files are released a few months after the annual release of NHIS microdata and are not available for the ER updates. Therefore, ER health insurance estimates stratified by poverty status are based on reported income only

and may differ from similar estimates produced later (e.g., in *Health, United States* [9]) that are based on both reported and imputed income.

**Region**—In the geographic classification of the U.S. population, states are grouped into the following four regions used by the U.S. Census Bureau:

| *Region* | *States included* |
|---|---|
| Northeast | Maine, Vermont, New Hampshire, Massachusetts, Connecticut, Rhode Island, New York, New Jersey, and Pennsylvania |
| Midwest | Ohio, Illinois, Indiana, Michigan, Wisconsin, Minnesota, Iowa, Missouri, North Dakota, South Dakota, Kansas, and Nebraska |
| South | Delaware, Maryland, District of Columbia, West Virginia, Virginia, Kentucky, Tennessee, North Carolina, South Carolina, Georgia, Florida, Alabama, Mississippi, Louisiana, Oklahoma, Arkansas, and Texas |
| West | Washington, Oregon, California, Nevada, New Mexico, Arizona, Idaho, Utah, Colorado, Montana, Wyoming, Alaska, and Hawaii |

**Expanded regions**—Based on a subdivision of the four regions into nine divisions. For this report, the nine Census divisions were modified by moving Delaware, the District of Columbia, and Maryland into the Middle Atlantic division. This approach was used previously by Holahan et al. (10).

## Additional Early Release Program Products

Two additional periodical reports are published through the NHIS ER Program. *Early Release of Selected Estimates Based on Data From the National Health Interview Survey* (11) is published quarterly and provides estimates of 15 selected measures of health, including insurance coverage. Other measures of health include estimates of having a usual place to go for medical care, obtaining needed medical care, influenza vaccination, pneumococcal vaccination, obesity, leisure-time physical activity, current smoking, alcohol consumption, HIV testing, general health status, personal care needs, serious psychological distress, diagnosed diabetes, and asthma episodes and current asthma.

*Wireless Substitution: Early Release of Estimates From the National Health Interview Survey* (12) is published in June and December and provides selected estimates of telephone coverage in the United States.

Other ER reports and tabulations on special topics are released on an as-needed basis. See: http://www.cdc.gov/nchs/nhis/releases.htm.

In addition to these reports, preliminary microdata files containing selected NHIS variables are produced as part of the ER Program. For each data collection year (January through December), these variables are made available three times: about September (with data from the first quarter), about December (with data from the first two quarters), and about March of the following year (with data from the first three quarters). NHIS data users can analyze these files through the NCHS Research Data Centers without having to wait for the final annual NHIS microdata files to be released.

New measures and products may be added as work continues and in response to changing data needs. Feedback on these releases is welcome (e-mail).

Announcements about ERs, other new data releases, and publications, as well as corrections related to NHIS, will be sent to members of the HISUSERS electronic mailing list. To join, visit the CDC website at: http://www.cdc.gov/subscribe.html and click on the National Health Interview Survey (NHIS) researchers button.

## Suggested Citation

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June 2015 | Issue Brief

# How Does Gaining Coverage Affect People's Lives? Access, Utilization, and Financial Security among Newly Insured Adults

Rachel Garfield and Katherine Young

## Executive Summary

In 2014, millions of people gained health insurance as the major coverage provisions of the Affordable Care Act (ACA) were implemented. While much attention has been paid to enrollment in new coverage options and changes in the number of uninsured over the past year, less is known about how this coverage has affected people's lives. This report, based on the 2014 Kaiser Survey of Low-Income Americans and the ACA, aims to understand the impact that gaining coverage has had on the lives of the "newly insured" adult population. The survey of 10,502 non-elderly adults was fielded between September 2 and December 15, 2014, with the majority of interviews (70%) conducted prior to November 15, 2014 (the start of the second open enrollment period). Additional detail on the survey methods is available in the methods appendix available online.

Based on the survey findings, approximately 11 million nonelderly adults were newly insured in 2014, meaning they reported that they obtained health coverage in 2014 and were uninsured before that coverage started. While many of these people gained coverage in the first quarter of 2014—which coincided with the "open enrollment period" for Marketplace coverage—most gained it after March 2014. Medicaid enrollment is available throughout the year, and some people were eligible to enroll in Marketplace coverage outside of open enrollment. In addition, people can gain non-ACA coverage at any time.

The vast majority (95%) of adults who gained coverage in 2014 have family income below 400% of poverty, the income range for financial assistance under the ACA, with more than half (53%) in low-income families (at or below 138% of poverty) and more than one in four (42%) in middle-income families (139 to 400% of poverty). While this income profile is not significantly different than that for the remaining uninsured population, the newly insured population is significantly more likely than the previously insured to be low- or middle-income and significantly less likely to be higher income (greater than 400% of poverty). Because of these differences in income, we restrict the analysis in this brief to the population below 400% of poverty.

### Who gained coverage in 2014?

Most newly insured adults are in working families, many with a part-time worker. Despite concerns about adverse selection into coverage, about half of newly insured adults are under age 35 (similar to those who remained uninsured), and newly insured adults are actually less likely to report fair or poor health than those who remained uninsured. Notably, newly insured adults were more likely to be female than their counterparts who remained without coverage, and they were also more likely to have insurance coverage for all their

children (if they had any) than those who remained uninsured. In addition, half of newly insured adults are people of color, and more than half do not have dependent children—groups that have historically faced disparities in coverage rates or exclusions from coverage in the past.

## How do newly insured adults access care?

A primary goal of expanding health insurance coverage is to help people access the medical services that they need. The survey findings reinforce other findings that insurance facilitates access to health care, indicating that adults who gained coverage in 2014 are more likely to be linked to regular care, less likely to postpone care when they need it, and more likely to use preventive services than those who remained uninsured. While some newly insured adults changed where they regularly go for care and most see private doctor's offices for their regular care, many continue to seek services from community clinics and health centers, which have historically served under-served populations such as the uninsured and may be the most available source of care in their area. Still, survey findings show that newly insured adults face some access barriers compared to adults who were insured before 2014. This finding may indicate that newly insured adults are not as settled into regular care as their previously insured counterparts; it may also reflect difficulty finding a provider, problems navigating the health system and health insurance networks, misunderstanding about how to use coverage and when to seek care, or concerns about out-of-pocket costs.

## How does coverage affect financial security?

Health care costs can be a major burden for low- and middle-income families. While many newly insured adults report difficulty affording their monthly premium, they also report lower rates of problems with medical bills and lower rates of worry about future medical bills than their uninsured counterparts. However, newly insured adults still face financial insecurity: they are more likely than those who had coverage before 2014 to worry about future medical bills, and they face general financial insecurity at rates similar to the uninsured. These patterns may indicate that while coverage can ameliorate some of the financial challenges that low- and moderate-income adults face, many will continue to face financial challenges in other areas of their lives.

## How do the newly insured view their coverage?

People's views of their plan may affect not only their use of their coverage but also the likelihood that they re-enroll in coverage or change plans. Survey results reveal that newly insured adults were very sensitive to cost in choosing their plan, placing a priority on cost over benefits and provider networks. A minority of both newly insured and previously insured adults reported problems in using their plan. However, newly insured adults were more likely than previously insured to say they do not understand the details of their plan and were more likely to give their plan a low rating. These findings indicate that additional education may be needed to help people understand their coverage.

## Policy Implications

As more and more evidence mounts to document coverage gains during the first year of the ACA, there is interest in understanding how these gains in coverage have affected the lives of the newly insured. Findings from the 2014 Kaiser Survey of Low-Income Americans and the ACA show, not surprisingly, that adults who gained coverage had better access to health care and better financial security from medical costs than those who remained without coverage. In addition, survey findings reveal few differences in outcomes among the

newly insured population by type of coverage, and the differences that do exist largely reflect Medicaid's role in targeting the lowest income and most vulnerable.

Still, comparison between newly insured adults and those who have had coverage since before 2014 shows some areas for ongoing attention as policymakers strive to translate coverage to care. Ongoing monitoring of newly insured adults' access and utilization is important to assess whether this population continues to face challenges or whether these differences subside over time.

## Introduction

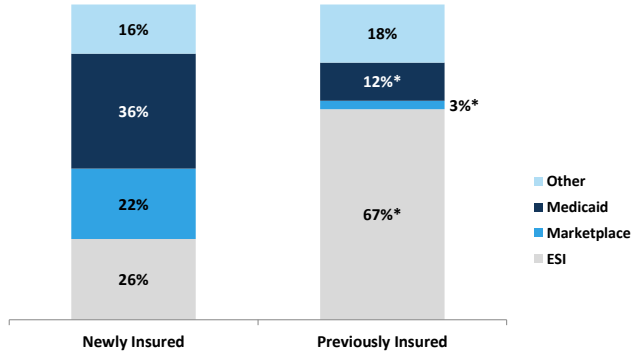
Lack of health insurance coverage for millions of people has been a long-standing policy challenge in the United States. Historically, most Americans received health coverage as an employer benefit through a job, but not all workers and their families were covered. Some people purchased coverage on their own, but this "non-group" coverage was costly and could be difficult to obtain. Public coverage provided assistance to many low- and middle-income people, but gaps in eligibility left many without an affordable coverage option. To increase the number of people with access to affordable coverage, the Affordable Care Act (ACA) included several provisions to address these challenges. The major coverage provisions, which went into effect in January 2014, include the expansion of Medicaid in many states and the availability of premium tax credits to purchase coverage through newly-established Health Insurance Marketplaces. These provisions have the potential to improve the availability and affordability of insurance coverage in the United States, with the ultimate goal of helping people access needed health services and reducing the financial burden of medical costs on low- and middle-income families.

While much attention has been paid to enrollment in new coverage options and changes in the number of uninsured since coverage provisions went into effect, less is known about how this coverage has affected people's lives. To help understand the early impact of the ACA, the Kaiser Family Foundation is conducting a series of comprehensive surveys of the low- and moderate-income population. The 2013 Kaiser Survey of Low-Income Americans and the ACA, fielded prior to the start of open enrollment for 2014 ACA coverage, provided a baseline snapshot of health insurance coverage, health care use and barriers to care, and financial security among insured and uninsured adults at the starting line of ACA implementation.[1] In Fall 2014, we conducted a second wave of the Kaiser Survey of Low-Income Americans and the ACA to understand how these factors have changed under the first year of the law's main coverage provisions. The survey of 10,502 nonelderly adults was fielded between September 2 and December 15, 2014, with the majority of interviews (70%) conducted prior to November 15, 2014 (the start of open enrollment for 2015 Marketplace coverage; Medicaid enrollment is open throughout the year). Questions asked about coverage in 2014, costs and scope of coverage, access to health care services, and affordability and family budgets. Additional detail on the survey methods is available in the methods appendix available online.

Based on the survey findings, approximately 11 million nonelderly adults were newly insured in 2014, meaning they reported that they obtained health coverage in 2014 and were uninsured before that coverage started. While the ACA was leading to major changes in health insurance coverage in 2014, these changes were occurring against the backdrop of the normal cycles of health coverage that people experience as their employment and income circumstances change. Therefore, though most people who report gaining coverage in 2014 did so through one of the pathways in place under the ACA (Figure 1), some people gained other coverage such as employer coverage. In addition, some people who were insured before 2014 also enrolled in ACA coverage options. For example, some people who were purchasing coverage on their own instead purchased that coverage through the new Marketplaces, and some people who lost coverage and were low- and middle-income took up Medicaid.

**Figure 1**

**Current Coverage Type Among Nonelderly Adults, by Newly Insured versus Previously Insured Status**

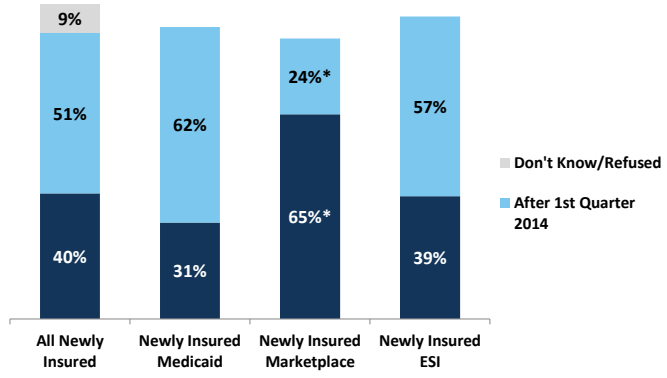



NOTE: Includes adults ages 19-64. "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014. "Newly Insured" include people who were insured as of interview date and gained coverage since January 2014. People who reported that they were waiting for their coverage to start or who were uncertain about when their coverage started or their previous insurance status are not included. "Other" coverage includes Medicare, non-Marketplace direct purchase, VA or military coverage, and other types of coverage. People who names a plan name that could not be identified as Medicaid, Marketplace, or employer coverage are also included in "other."
* Significantly different from Newly Insured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

Under the ACA, most people can only purchase Marketplace coverage during "open enrollment." For coverage that started in 2014, open enrollment was between October 2013 and the end of March 2014; however, due to website glitches, people who started an application before March 31, 2014 were allowed to enroll through April 2014. In addition, "special enrollment periods" may be available for those undergoing certain life events (such as having a baby, getting married, or moving to a new state). Medicaid enrollment is open throughout the year, and enrollment in job-based coverage is generally timed to start of a job or fall open enrollment periods if the employer offers a choice of plans. While many (40%) newly insured adults gained their coverage in the first quarter of 2014, most gained it after March 2014. Not surprisingly, given enrollment periods, newly insured Marketplace enrollees were most likely to gain coverage in the first quarter, whereas newly-insured adults with Medicaid or employer coverage were more likely to gain coverage throughout the year (Figure 2).

**Figure 2**

**Timing of Enrollment in Coverage Among Low- and Middle-Income Newly-Insured Adults, by Type of Coverage**




NOTE: Includes adults ages 19-64. "Newly Insured" include people who were insured as of interview date and gained coverage since January 2014. Share of Newly Insured Medicaid, Marketplace, and ESI reporting "Don't Know/Refused" not shown because they do not meet minimum standard for statistical reliability. * Significantly different from Medicaid at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

The vast majority of adults who gained coverage in 2014 have family income below 400% of poverty, the income range for financial assistance under the ACA. More than half (53%) of adults who gained coverage in 2014 have family income at or below 138% of poverty, or about $27,300 for a family of three, and more than one in four (42%) has family incomes in the range for tax credits (139 to 400% of poverty). This income profile is not significantly different than that for the remaining uninsured population. However, the newly insured

population is significantly more likely than the previously insured to be low- and middle-income and significantly less likely to be higher income (greater than 400% of poverty). This pattern reflects the longstanding association between being low income and lacking insurance coverage.

This report aims to understand the impact that gaining coverage has had on the lives of low- and middle-income "newly insured" adults. Based on the 2014 Kaiser Survey of Low-Income Americans and the ACA, it describes who was newly insured as of Fall 2014 and compares this population to their uninsured and previously insured counterparts (see text box below for definitions of these terms); provides information on how the newly insured view their coverage and any problems they have encountered, and examines how the newly insured fare with respect to access to medical care and financial burden. Because adults who were previously insured were more likely to be higher income, and because income is associated with many of the outcomes of interest, the analysis in this brief is restricted to only the population below 400% of poverty, who we call "low- and middle-income adults." This approach enables us to compare the newly insured to the uninsured and previously insured with a similar income profile. Because timing of coverage may also affect some of the outcomes of interest, we also conducted sensitivity analysis to examine whether patterns among the newly insured differed by timing of coverage and, where relevant, report those as well.

### Definitions of Key Terms Used in This Report

Throughout this report, we use the following terms to refer to people by whether they have insurance coverage and when they gained their coverage:

- *Uninsured:* This group includes people who lacked insurance coverage at the time of the survey. While some of these people lost coverage during 2014, the vast majority (77%) lacked coverage since at least January 2014.
- *Newly Insured:* This group includes people who were insured at the time of the survey, indicated that their coverage started on or after January 2014, and said that they lacked insurance coverage before their current coverage began.
- *Previously Insured:* This group includes people who were insured at the time of the survey and had been insured since before January 2014. Some of these individuals may have changed the type of coverage they had in 2014, but they had no period of uninsurance before their current coverage began.

In addition, to increase the comparability between coverage groups, we restrict this analysis to low- and middle-income nonelderly adults. Income groups are defined as:

- *Low-Income:* People in families with incomes up to or including 138% of the poverty level. In 2014, 138% of poverty was $27,300 for a family of three.
- *Middle-Income:* People in families with incomes between 139 and 400% of the poverty level. In 2014, 400% of poverty was $79,200 for a family of three.

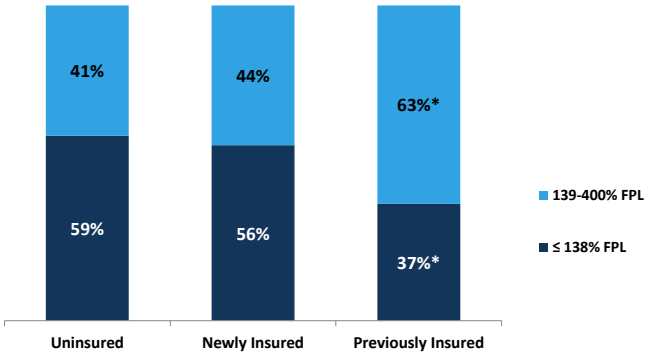
# Who gained coverage in 2014?

In some ways, the low- and middle- income "newly insured" population (those who gained coverage in 2014 and were uninsured before gaining that coverage) and "uninsured" population (those who lacked coverage in fall 2014) resemble each other. For example, they are similar with respect to income, work status, age, and family type, and they differ from the low- and middle-income "previously insured" population (people who had coverage before 2014 and still had it in 2014) on these factors. However, the newly insured population differs from their counterparts who remained without coverage on some important factors, such as race/ethnicity, gender, and immigration status. These differences in part reflect ongoing barriers to coverage among some groups and in part reflect higher take-up among others.

**Even within the low- and middle-income population, newly insured adults are more likely to be lower-income than previously insured adults.** More than half (56%) of adults in the income range for ACA financial assistance are in families at or below 138% of poverty, a rate that is not statistically significantly different from the remaining uninsured. In contrast, previously insured adults in the low- and middle-income range are more likely to fall into the middle-income range, with 63% having family incomes between 139 and 400% of poverty (Figure 3). The fact that newly insured adults are more likely to be in the lowest income group may have implications for their financial stability and ability to navigate the health system, as lower-income individuals face more barriers to health care than higher-income people.

Figure 3

**Income Distribution Among Low- and Middle-Income Nonelderly Adults, By Insurance Coverage in Fall 2014**

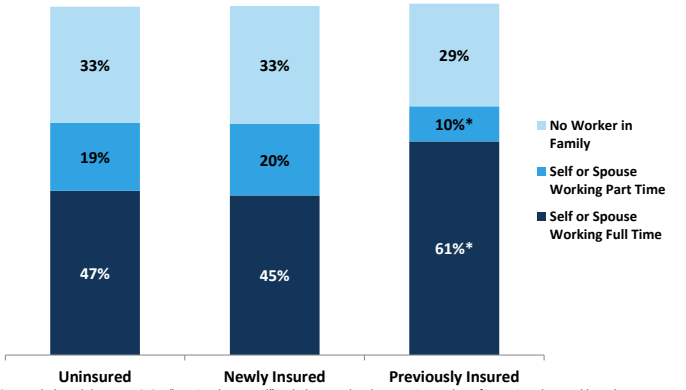



NOTE: Includes adults ages 19-64. The federal poverty level (FPL) in 2014 was $19,790 for a family of three. "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014. "Newly Insured" include people who were insured as of interview date and gained coverage since January 2014. "Uninsured" includes people who lacked coverage as of the interview date. Totals may not sum to 100% due to rounding.
* Significantly different from Newly Insured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

Not surprisingly, adults who are newly insured through Medicaid are significantly more likely to be in the lowest income group than adults who gained Marketplace or other private coverage, who are more likely to be middle-income (data not shown). Medicaid eligibility is targeted to adults with the lowest incomes, with the ACA extending eligibility to most adults with incomes at or below 138% in states that expanded. Some adults, such as pregnant women or working adults with disabilities, may qualify for Medicaid at higher incomes through pathways in place before the ACA.

Figure 4

**Family Work Status Among Low- and Middle-Income Nonelderly Adults, by Insurance Coverage in Fall 2014**




NOTE: Includes adults ages 19-64. "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014. "Newly Insured" include people who were insured as of interview date and gained coverage since January 2014. "Uninsured" includes people who lacked coverage as of the interview date. Those who refused or did not know answers to work status questions not shown. * Significantly different from Newly Insured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

**Newly insured adults are more likely to be in a family working part-time (versus full-time) than their previously insured counterparts.** A majority of low- and middle-income adults who gained coverage in 2014 live in a family with a worker, meaning either they or their spouse works full time (45%) or part time (20%), and a third (33%) are in a family with no worker (Figure 4). This distribution is not significantly different from the uninsured. However, previously insured adults are more likely than newly insured adults to have a full-time worker in the family and less likely to have a part-time worker. This pattern reflects the historical ties between work and health insurance, since most people who had coverage before the ACA obtained that coverage through a job and people without full-time employment had limited access to affordable coverage. With new coverage provisions in place as of 2014, there were more options for health insurance outside employment, particularly for people in states that expanded Medicaid.

Within the newly insured population, those newly insured through Medicaid were less likely than adults with other coverage (including Marketplace) to be in a full-time working family (data not shown). This finding is not surprising given that Medicaid eligibility targets those in the lowest income bracket, and people with lower incomes are less likely to work full-time. However, compared to adults who had Medicaid coverage before 2014, those who gained Medicaid coverage were more likely to be in a family with a worker. With the expansion of Medicaid in many states, eligibility levels were raised to levels where one could work part-time and still meet income limits.

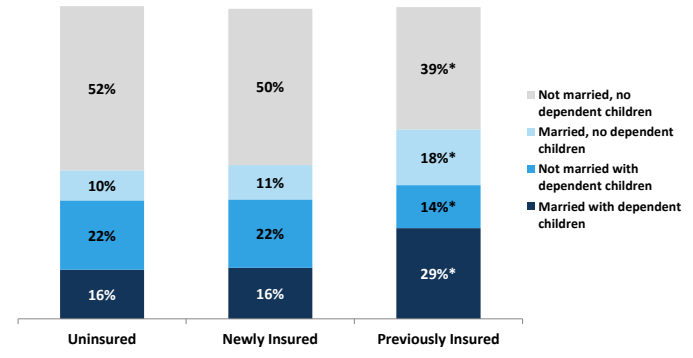
**Half of newly insured adults are under age 35.** Despite concerns that many people who sign up for coverage would be older adults who were more at risk for health problems, half of newly insured adults were under age 35 (Appendix Table 1). Nearly a fifth (19%) were aged 19 to 25, the so-called "young invincible" group. The age distribution of the newly insured was similar to the remaining uninsured population but younger than the previously insured population. These differences likely reflect the fact that those who lacked coverage prior to 2014 were more likely to be young, since younger adults have looser ties to employment and lower incomes. Within the newly insured population, there were no significant differences in age distribution between Medicaid and Marketplace enrollees, though newly insured adults with employer coverage were less likely than those who gained ACA coverage to be age 45-64.

**The newly insured population is more likely to be female than their counterparts who remained without coverage.** Nearly six in ten (58%) of the newly insured population is female, a share significantly higher than that among the remaining uninsured (45%) but not significantly different from the previously insured (Appendix Table 1). Women have historically had a lower uninsured rate than men,[2] and the gender patterns in who gained coverage may reflect women taking up coverage at a higher rate than men. There were no significant differences in gender by coverage type within the newly insured population.

**More than half of newly insured adults are adults without dependent children, a group that has generally been excluded from publicly-financed health coverage in the past.** About six in ten (61%) newly insured adults do not have dependent children, and 72% are not married (Figure 5). These shares are similar to those among the remaining uninsured population. In the past, non-elderly adults without dependent children could only qualify for Medicaid if they were disabled or pregnant, and private coverage as an adult dependent was generally restricted to spouses. With new coverage expansions, some people who faced limits to accessing coverage due to family structure were able to gain coverage. Previously insured adults were most likely to be married, perhaps reflecting the availability of family coverage in the private market. Within the newly insured population, there were no significant differences by coverage in the share of adults who were not married without dependent children.

Figure 5

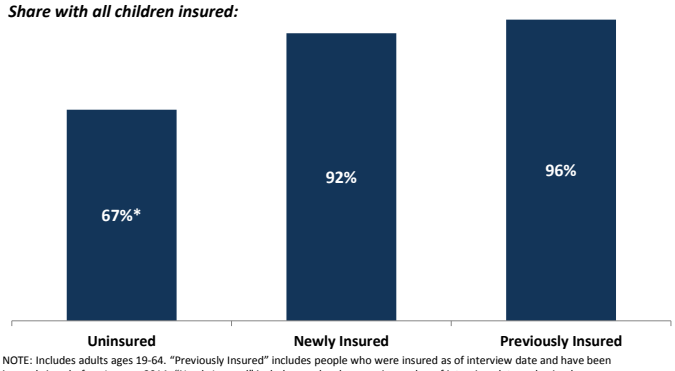
**Family Status of Low- and Middle-Income Nonelderly Adults, By Insurance Coverage in Fall 2014**




NOTE: Includes adults ages 19-64. "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014. "Newly Insured" include people who were insured as of interview date and gained coverage since January 2014. "Uninsured" includes people who lacked coverage as of the interview date.
* Significantly different from Newly Insured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

Figure 6

**Share of Low- and Middle-Income Parents Whose Children Are Insured, by Parent Insurance Coverage in Fall 2014**

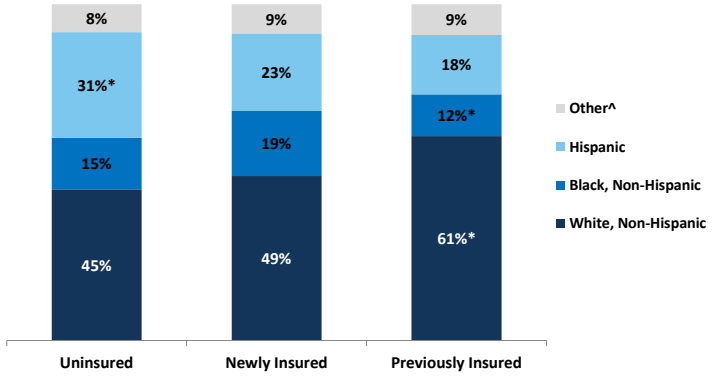



NOTE: Includes adults ages 19-64. "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014. "Newly Insured" include people who were insured as of interview date and gained coverage since January 2014. "Uninsured" includes people who lacked coverage as of the interview date. Children includes dependent children under age 19. * Significantly different from Newly Insured at the p<0.05 level. Share of newly insured with some or all children uninsured not shown because estimate does not meet standard for statistical reliability.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

**Among parents, newly insured adults were less likely to have uninsured children than adults who remained without coverage.** The vast majority of uninsured children are eligible for coverage under the ACA: Medicaid and the Children's Health Insurance Program (CHIP) are available to most children in low-income families, and children may be covered along with their parents in Marketplace coverage. Research has found that parent coverage in public programs is associated with higher enrollment of eligible children.[3] Coverage patterns in 2014 support this finding: newly insured parents were less likely than uninsured parents to have uninsured children, and nearly all newly insured and previously insured parents had all of their children insured (Figure 6).

**Over half of newly insured adults are people of color.** Reflecting historical patterns of the uninsured being more likely to be people of color than the insured, the newly insured are less likely than the previously insured to be White, Non-Hispanic, though they are no more or less likely to be White, Non-Hispanic than adults who remained uninsured (Figure 7). Notably, the newly insured population is less likely to be Hispanic than the remaining uninsured. This pattern likely reflects a combination of factors, including language barriers, immigration policy, and work status, that led to the remaining uninsured being disproportionately Hispanic. There were no significant differences in race/ethnicity of the newly insured population by type of coverage gained.

Figure 7
**Race/Ethnicity of Low- and Middle-Income Nonelderly Adults, By Insurance Coverage in Fall 2014**

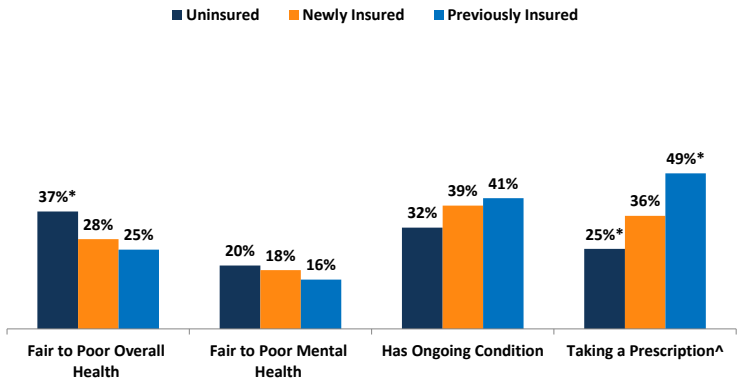



NOTE: Includes adults ages 19-64. "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014. "Newly Insured" include people who were insured as of interview date and gained coverage since January 2014. "Uninsured" includes people who lacked coverage as of the interview date. ^Comprises Asian, Pacific Islander, American Indian, Alaskan Native, "Other", and "Don't Know."
* Significantly different from Newly Insured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

**The vast majority of newly insured adults are U.S. citizens.** Nearly nine in ten (87%) of newly insured adults are citizens, and 7% are legal immigrants (Appendix Table 1). The remainder is immigrants who are in the United States without a green card. While federal law bars undocumented immigrants from ACA coverage either through Medicaid or the Marketplace, as documented elsewhere, immigrants without green cards may acquire coverage through a job, directly from insurers outside the Marketplace, or through state-only programs.[4,5,6] However, bans on coverage among undocumented immigrants are evident in the higher share (15%) of remaining uninsured who fall into this category. Among the previously insured, nearly all (97%) are U.S. citizens or legal immigrants. Within the newly insured population, there were no significant differences in the share of US citizens by type of coverage.

**Newly insured adults do not differ significantly from the previously insured on most measures of health status, but they are less likely than their uninsured counterparts to report fair or poor health.** Nearly three in ten (28%) newly insured adults rate their overall health as fair or poor, a share that is not significantly different from the previously insured but is lower than the remaining uninsured (Figure 8). Nearly a fifth (18%) reports their mental health is fair or poor and about four in ten (39%) report that they have an ongoing medical condition that requires regular care, rates about equal to adults in other coverage groups. These findings refute the idea that those who gained coverage are more likely than those who did not to be in poor health or feel they need medical services. However, newly insured adults *are*

Figure 8
**Health Status Among Low- and Middle-Income Nonelderly Adults, by Insurance Coverage in Fall 2014**




NOTE: Includes adults ages 19-64. "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014. "Newly Insured" include people who were insured as of interview date and gained coverage since January 2014. "Uninsured" includes people who lacked coverage as of the interview date. ^Does not include birth control.
* Significantly different from Newly Insured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

less likely than the previously insured and more likely than the uninsured to say they take a prescription on a regular basis.

Within the newly insured group, adults with Medicaid are more likely say they receive care for an ongoing condition than those with Marketplace coverage (data not shown). Further, adults newly insured through Medicaid were more likely to report fair or poor overall or mental health, to have an ongoing condition, or to take a prescription drug than those newly insured through employer coverage. Several pre-ACA Medicaid eligibility pathways specifically target people with health problems, and some gaining coverage may have qualified through these routes. Many adults also enroll in Medicaid after coming in contact with the medical system, which may explain why these adults are more likely than other newly insured to have a chronic condition.

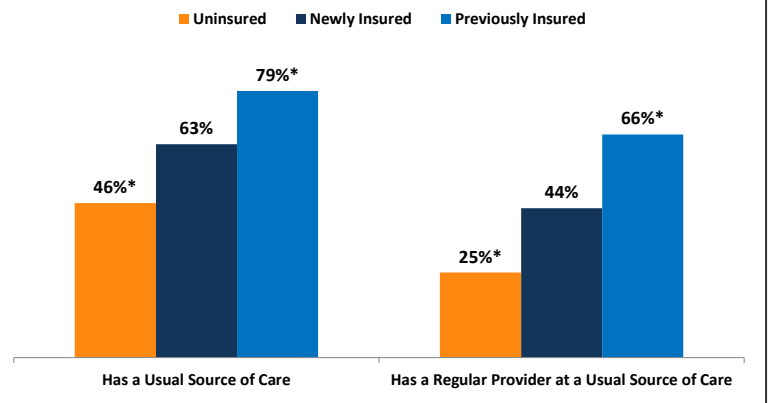
## How do newly insured adults access care?

The ultimate goal of expanding health insurance coverage is to help people access the medical services that they need. A large body of literature has documented that people with insurance are more likely to be linked to regular care, are less likely to postpone care when they need it, and have an easier time accessing services. The survey findings reinforce those findings, indicating that adults who gained coverage in 2014 have better access to care than those who remained without coverage. In addition, the survey findings provide insight into patterns of care among the newly insured and remaining insured. While some newly insured adults report changing where they regularly go for care, many say they continue to seek services from community clinics and health centers, which have historically provided care to under-served populations such as the uninsured.

**Adults who gained coverage are more likely to be linked to care than those who remained uninsured.** Newly insured adults were more likely than those who remained uninsured in Fall 2014 to have a usual source of care, or a place to go when they are sick or need advice about their health (not counting the emergency room); they were also more likely to have a regular doctor at their usual source of care (Figure 9). Having a usual source of care or regular doctor is an indicator of being linked in to the health care system and having regular access to services. These patterns reinforce a large body of research that finds that gaining coverage is associated with improved access to care. However, results also indicate that the newly insured are less likely than the previously insured to have a usual source of care or regular doctor. This finding may indicate that newly insured adults are still navigating the health care system and are not as settled into regular care as their previously insured counterparts. There were no differences in the share with a usual source of care by type of coverage among the newly insured, but adults newly insured through Medicaid were more likely than those newly insured through Marketplace or employer coverage to say they have a regular doctor at their usual source of care.

Figure 9

**Share of Low- and Middle-Income Insured Adults with a Usual Source of Care or Regular Provider, by Insurance Coverage**




NOTE: Includes insured adults ages 19-64. Respondents who indicate their usual source of care is the emergency department are not included. "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014; some of these people may have switched coverage type. "Newly Insured" include people who were insured as of interview date and gained coverage since January 2014. * Significantly different from Newly Insured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

**Newly insured adults were more likely to change where they usually go for care than their uninsured or previously insured counterparts.** A fifth of newly insured adults who have a usual source of care reported that they changed the place they usually go for care since gaining their coverage (Figure 10). This rate is twice as high as the share of previously insured adults who changed their usual source of care in 2014 (it is also higher than the share of uninsured adults, but the difference is not statistically significant). About half of newly insured adults who changed their site of care reported that it was due to their insurance, a significantly higher rate than the other coverage groups.

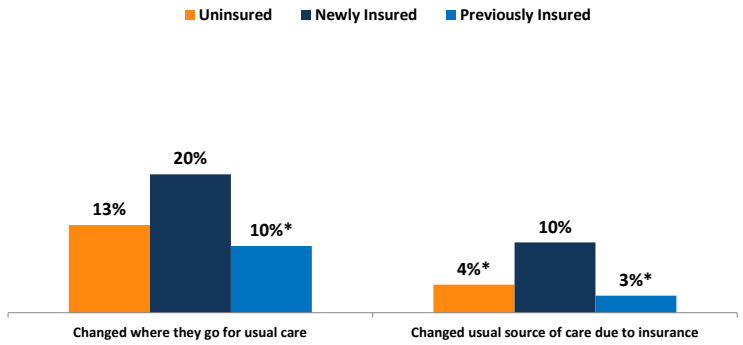
**While clinics remain an important source of care for the newly insured, most rely on private doctor's offices for their regular care.** Among newly insured adults who have a usual source of care, about half (51%) say it is a doctor's office or HMO, and more than a third (34%) say it is a clinic or health center (Figure 11). In contrast, about half of uninsured adults with a usual source of care rely on a clinic or health center, and less than a third use a doctor's office or HMO for their regular care. Previously insured adults were most likely to use a doctor's office or HMO and least likely to use clinics as their usual source of care. Historically, clinics and health centers were crucial "safety net" providers for uninsured people. As newly insured gain coverage, many continue to rely on these providers, but they are also more likely to change to a doctor's office for their care.

**Like their previously insured counterparts, most newly insured adults choose their site of care based on convenience or providers, rather than affordability or lack of options.** In the past, many uninsured adults reported that they chose

Figure 10

**Change in Usual Source of Care Among Low- and Middle-Income Nonelderly Adults, by Insurance Coverage in Fall 2014**

*Among those with a usual source of care, share who:*

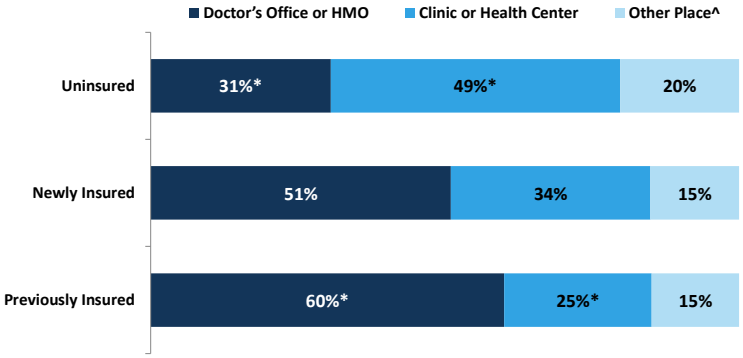



NOTE: Includes adults ages 19-64. "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014. "Newly Insured" include people who were insured as of interview date and gained coverage since January 2014. "Uninsured" includes people who lacked coverage as of the interview date.
* Significantly different from Newly Insured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

Figure 11

**Type of Place Used for Usual Source of Care among Low- and Middle-Income Adults, by Insurance Coverage**

*Among those with a usual source of care, share using:*

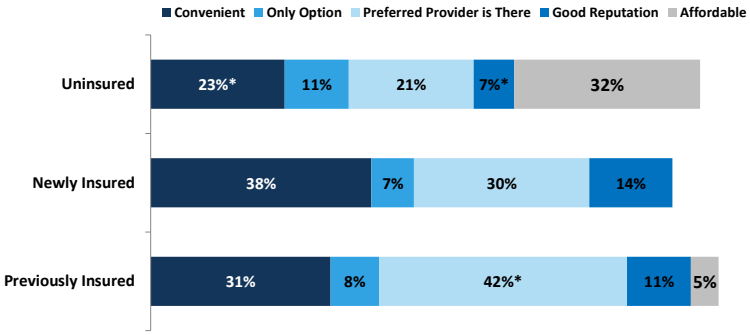



NOTE: Includes adults ages 19-64. "Other" includes urgent care centers, hospital outpatient departments, some other location, and don't know/refused. Respondents who indicate their usual source of care is the emergency department are not included. "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014; some of these people may have switched coverage type. "Newly Insured" include people who were insured as of interview date and gained coverage since January 2014. * Significantly different from Newly Insured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

Figure 12

**Reason for Choosing Usual Source of Care among Low- and Middle-Income Adults, by Insurance Coverage**

*Among those with a usual source of care, share choosing because it is:*



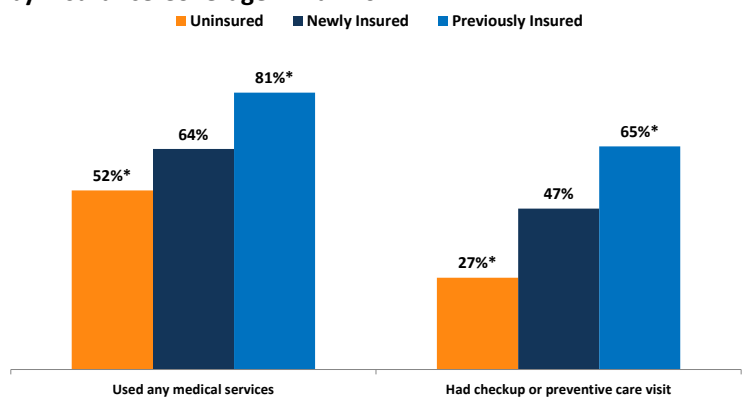

NOTE: Includes adults ages 19-64. Respondents who indicate their usual source of care is the emergency department are not included. Share of Newly Insured reporting "Affordable" not shown because does not meet minimum standard for statistical reliability. "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014; some of these people may have switched coverage type. "Newly Insured" include people who were insured as of interview date and gained coverage since January 2014. * Significantly different from Newly Insured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

their usual source of care because it was affordable, a pattern that is also seen among adults who were uninsured in 2014. In contrast, adults who gained coverage in 2014 were more likely to say they chose their usual source of care because it was convenient (38%), and many chose it because the provider they prefer to see is there (30%) (Figure 12). They were also more likely than the uninsured to choose their site of care because it has a good reputation. Previously insured adults were more likely than newly insured to choose their usual source of care because their preferred provider is there. These differences may indicate that the previously insured adults have stronger ties to their providers, having been linked to care for a longer period of time.

**Mirroring patterns of being linked to care, newly insured adults are more likely than their uninsured counterparts to have used medical services or received preventive care.** Overall, nearly two-thirds (64%) of adults who gained coverage in 2014 said they used at least one medical service since gaining their coverage, and nearly half (47%) had received a preventive visit or check-up (Figure 13). These rates were significantly higher than those for the uninsured in 2014 but were lower than the previously insured reported for 2014. These patterns are not unexpected given the large body of research showing that people with insurance coverage are more likely than those without to use care, including preventive care. The differences between the newly insured and previously insured partially reflect the shorter period of time that the newly insured had their coverage, since most people's coverage started at least several months into 2014. Analysis of the type of care received (not shown) indicates that differences exist for outpatient services (well-care or sick care) and mental health services but not for hospital-based services, including emergency care, indicating that patterns differ for discretionary versus emergent or high-acuity services. Within the newly insured, adults with employer coverage were less likely than those with Medicaid to have used medical services since gaining coverage, and they were less likely than either Medicaid or Marketplace enrollees to have received a preventive visit since gaining coverage.

Figure 13

**Use of Care Among Low- and Middle-Income Nonelderly Adults, by Insurance Coverage in Fall 2014**

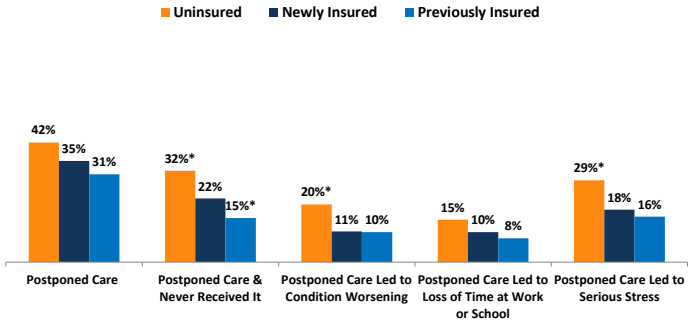



NOTE: Includes adults ages 19-64. "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014. "Newly Insured" include people who were insured as of interview date and gained coverage since January 2014. "Uninsured" includes people who lacked coverage as of the interview date.
* Significantly different from Newly Insured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

**Newly insured adults were less likely than uninsured adults to never receive needed care or face serious consequences of postponing care.** While there were no significant differences between coverage groups in the share who postponed care, newly insured adults were significantly less likely than uninsured adults to say they never got the care they needed (22% versus 32%) (Figure 14). They were also less likely to report that postponing care led to a condition worsening or serious stress (there was no significant difference in the share who said postponing care led to time away from work or school). Still, the newly insured were more likely than the previously insured to report problems postponing and never receiving needed care, reflecting some unmet need among those who gained coverage in 2014.

Figure 14

**Unmet Need for Care Among Low- and Middle-Income Nonelderly Adults, by Insurance Coverage in Fall 2014**

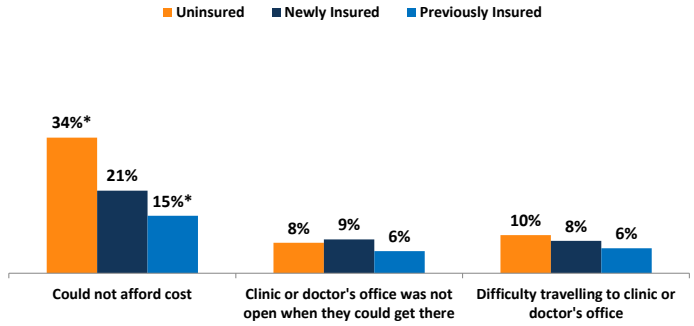



NOTE: Includes adults ages 19-64. "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014. "Newly Insured" include people who were insured as of interview date and gained coverage since January 2014. "Uninsured" includes people who lacked coverage as of the interview date.
* Significantly different from Newly Insured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

Figure 15

**Reasons for Postponing Care Among Low- and Middle-Income Nonelderly Adults, by Insurance Coverage in Fall 2014**

*Share who say they postponed care and did so because:*



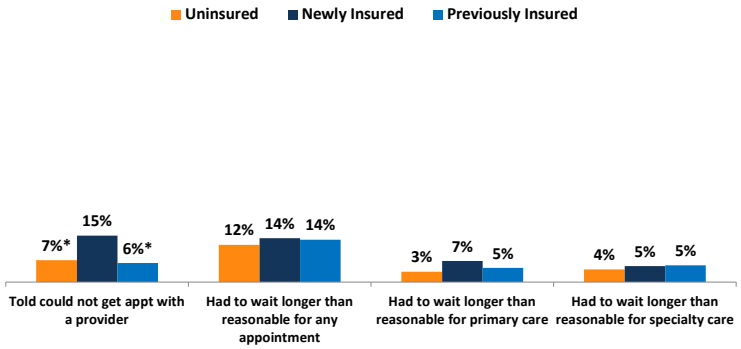

NOTE: Includes adults ages 19-64. "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014. "Newly Insured" include people who were insured as of interview date and gained coverage since January 2014. "Uninsured" includes people who lacked coverage as of the interview date.
* Significantly different from Newly Insured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

Unmet need could be related to several factors, including difficulty finding a provider, problems navigating the health system and health insurance networks, misunderstanding about how to use coverage and when to seek care, or concerns about out-of-pocket costs. When asked why they postponed care, newly insured adults were less likely than uninsured adults to say cost was a factor (21% versus 34%), but they were more likely than previously insured adults (15%) to say cost was a factor (Figure 15). While Medicaid enrollees pay no or nominal cost-sharing, adults with Marketplace coverage may face out-of-pocket costs, particularly if they do not choose a silver plan (cost sharing subsidies for people with incomes below 250% of poverty are only available if they choose a silver plan).[7] In addition, as discussed earlier in this brief, newly insured adults have lower incomes than previously insured adults, which means cost-sharing may pose a bigger burden for them. When asked whether being able to get to the provider when it was open or difficulty traveling to the provider were factors, there were no significant differences in the shares of uninsured, newly insured, and previously uninsured adults who said these things caused them to postpone care.

**Though most adults did not report problems getting medical appointments, newly insured adults were more likely than other adults to say a provider would not take them as a new patient.** Compared to 7% of uninsured and 6% of previously insured adults, 15% of newly insured adults say that a provider told them he/she would not take them as a new patient (Figure 16). Most newly insured adults who reported this problem said it was because the provider did not take their coverage, a rate higher than that for the previously insured. The lower rates among the uninsured likely reflect this group's lower propensity to seek care, as detailed elsewhere. The higher rates among the newly insured may reflect problems with network adequacy, outdated or inaccurate plan information, or disruptions in care patterns that

Figure 16

**Problems Getting Medical Appointments Among Low- and Middle-Income Nonelderly Adults, by Insurance Coverage in Fall 2014**




NOTE: Includes adults ages 19-64. "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014. "Newly Insured" include people who were insured as of interview date and gained coverage since January 2014. "Uninsured" includes people who lacked coverage as of the interview date.
* Significantly different from Newly Insured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

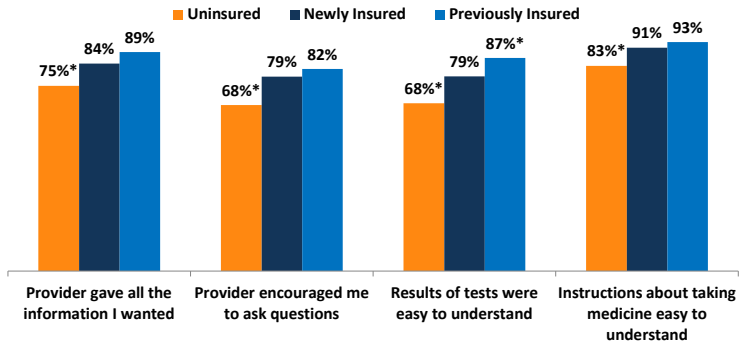
led newly insured adults to be more likely to seek a new provider.

**Among adults who received care, newly insured adults were more likely than uninsured to report effective communication with their providers about their care.** Once people get into care, health literacy—or "patients' ability to obtain, process, and understand the basic health information and services they need to make appropriate health decisions"[8]—plays an important role in how that care affects health outcomes. Health literacy depends on a range of factors related to patients (e.g., engagement in care), providers (e.g., how the information is communicated), service setting (e.g., the length of time of the interaction), and the nature of the visit (e.g., the complexity of health information). In general, it appears that adults with coverage are more likely than those without coverage to report effective communication with their provider, a finding that may be linked to having a regular doctor. Adults who were newly insured were significantly more likely than their uninsured counterparts to report effective communication, including getting all the information they wanted from the provider; feeling encouraged to ask questions; understanding their test results; and understanding how to take their medication (Figure 17). Within the group of newly insured adults, there were no significant differences by coverage type. Further, the only outcome for which there was a significant difference between the newly and previously insured was understanding test results.

**Figure 17**

**Views of Health Care Encounter Among Low- and Middle-Income Nonelderly Adults, by Insurance Coverage in Fall 2014**

*Share saying happened "always" or "most of the time" they visited provider:*




NOTE: Includes adults ages 19-64 who had at least one provider visit. "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014. "Newly Insured" include people who were insured as of interview date and gained coverage since January 2014. "Uninsured" includes people who lacked coverage as of the interview date.
* Significantly different from Newly Insured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

## How does coverage affect financial security?

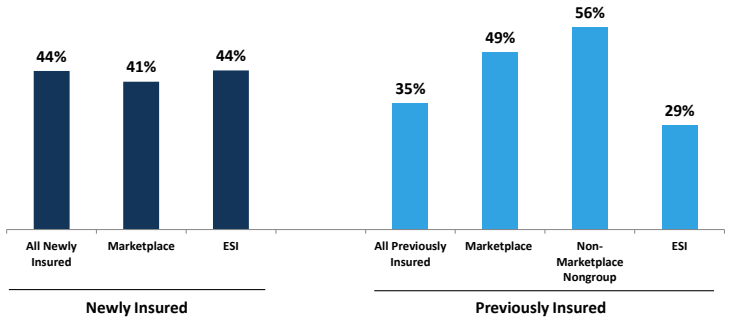
Health care costs can be a major burden for low-income families. While many newly insured adults report difficulty affording their monthly premium, they also report lower rates of problems with medical bills and lower rates of worry about future medical bills than their uninsured counterparts. However, newly insured adults still face financial insecurity: they are more likely than those who had coverage before 2014 to worry about future medical bills, and they face general financial insecurity at rates similar to the uninsured. These patterns may indicate that while coverage can ameliorate some of the financial challenges that low- and moderate- income adults face, many will continue to face financial challenges in other areas of their lives.

**Many low- and middle-income insured adults report difficulty paying their monthly premium.** Among adults who say that they pay a monthly premium for their health coverage, more than four in ten newly insured adults (44%) and over a third of previously insured adults (35%) say it is somewhat or very difficult to afford this cost (Figure 18). While rates of difficulty varied by type of coverage among the newly insured, these differences by type of coverage were not statistically significant. Notably, though a majority (85%) of Marketplace enrollees receive premium subsidies,[9] many (41% of the newly insured and 49% of the previously insured) still report difficulty affording their premium cost.

Figure 18

**Difficulty Affording Health Insurance Premiums among Low- and Middle-Income Insured Adults, by Insurance Coverage**

*Share reporting it is "somewhat difficult" or "very difficult" to pay premium:*

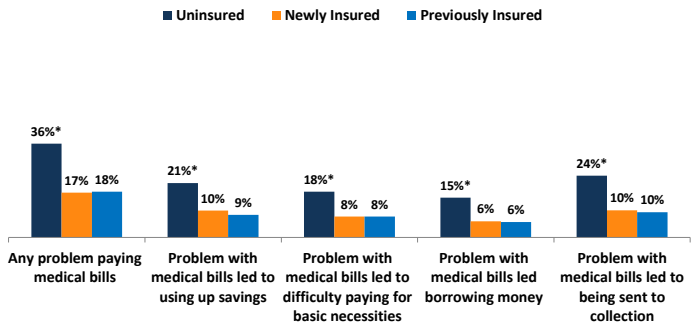



NOTE: Includes insured adults ages 19-64. "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014; some of these people may have switched coverage type. "Newly Insured" include people who were insured as of interview date and gained coverage since January 2014.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

**However, coverage does provide financial protection from medical bills and eases concern over affording medical care.** Compared to the uninsured, both newly insured and previously insured adults report lower rates of difficulty paying medical bills. Despite being less likely to use services, over a third (36%) of uninsured adults report a problem paying medical bills, a rate twice as high as either the newly insured or previously insured (Figure 19). Uninsured adults were also more likely to report serious consequences from medical bills, such as using up their savings, having difficulty paying for necessities, borrowing money, or being sent to collection. On all measures of problems from medical bills, there were no significant differences between the newly and previously insured.

Figure 19

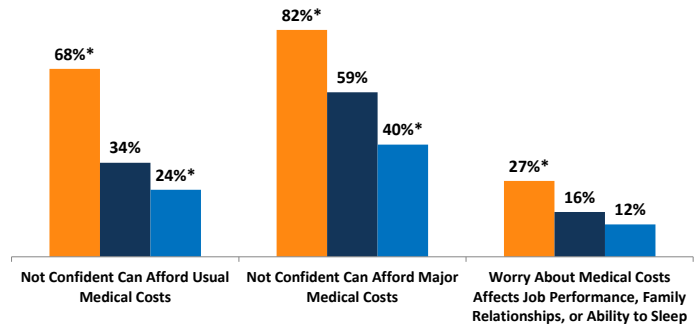
**Problems Paying Medical Bills Among Low- and Middle-Income Nonelderly Adults, by Insurance Coverage in Fall 2014**




NOTE: Includes adults ages 19-64. "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014. "Newly Insured" include people who were insured as of interview date and gained coverage since January 2014. "Uninsured" includes people who lacked coverage as of the interview date.
* Significantly different from Newly Insured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

Figure 20

**Financial Insecurity Over Medical Costs Among Low- and Middle-Income Nonelderly Adults, by Insurance Coverage in Fall 2014**




NOTE: Includes adults ages 19-64. "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014. "Newly Insured" include people who were insured as of interview date and gained coverage since January 2014. "Uninsured" includes people who lacked coverage as of the interview date. * Significantly different from Newly Insured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

In addition to being less likely to report experiencing financial strain due to medical bills, insured adults are less likely than uninsured to report living with worry about their ability to afford medical care in the future. Newly insured adults were half as likely as uninsured to say they lack confidence in their ability to afford the cost of care for services they typically require (34% versus 68%), and they were also significantly less likely to

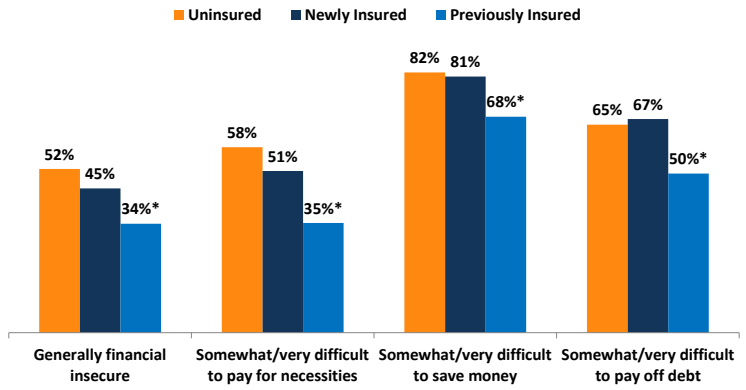
say they lack confidence in their ability to afford the cost of a major illness (59% versus 82%) (Figure 20). In some cases, this concern has implications for people's level of stress and affects their daily lives: newly insured adults were less likely than uninsured to say that worry over affording medical costs has affected their job performance, family relationships, or ability to sleep. However, in contrast to reported problems with medical bills, newly insured adults were more likely than previously insured adults to report financial insecurity over future medical bills. Among the newly insured, there were no significant differences in lack of confidence by coverage type. It is possible that newly insured adults have less confidence in the protection offered by their coverage, or it is possible that their recent experience without coverage led them to be more concerned about future coverage and costs.

**Many newly insured adults still face financial insecurity in areas outside of health care costs.** While coverage provides some financial protection from medical bills, newly insured adults are not less likely than uninsured adults to report facing general financial challenges in other areas of their lives. For example, there are no significant differences in the share of uninsured and newly insured adults reporting general financial insecurity or in the share reporting difficulty paying for necessities, saving money, or paying off debt (Figure 21). However, previously insured adults were less likely than newly insured to report these financial challenges.

Within the group of newly insured adults, those with Medicaid were more likely than those with other types of coverage to report that they were financially insecure and more likely to say they have difficulty paying for necessities (data not shown). This finding is not surprising, given that Medicaid is targeted to adults with the lowest incomes.

Figure 21

**Financial Security Among Low- and Middle-Income Nonelderly Adults, by Insurance Coverage in Fall 2014**




NOTE: Includes adults ages 19-64. "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014. "Newly Insured" include people who were insured as of interview date and gained coverage since January 2014. "Uninsured" includes people who lacked coverage as of the interview date. * Significantly different from Newly Insured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

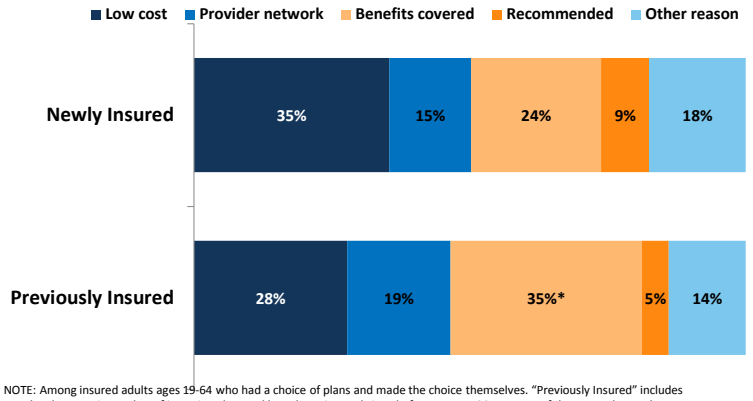
## How do the newly insured view their coverage?

People's views of their plan may affect not only their use of their coverage but also the likelihood that they re-enroll in coverage or change plans. Survey results reveal that newly insured adults were very sensitive to cost in choosing their plan, placing a priority on cost over benefits and provider networks. A minority of all insured adults reported problems in using their plan. However, newly insured adults were more likely than previously to say they do not understand the details of their plan and were more likely to give their plan a low rating. These findings indicate that additional education may be needed to help people understand their coverage.

**Newly insured adults were less likely to prioritize scope of coverage in choosing their plan than previously insured adults.** Among adults who say they had a choice of plans and made the choice themselves, under a quarter (24%) of newly insured adults say they chose their plan because of the benefits covered, compared to 35% of previously insured adults (Figure 22). Newly insured adults were most likely to say they chose their plan because of low cost (35%); while this share was higher than the previously insured (28%), the difference was not statistically significant. Newly insured adults may have been less likely to choose based on benefits because new regulations set a minimum scope of coverage across new plans (so called "essential health benefits"), but "grandfathered" pre-existing plans are not held to the same requirement. Alternatively, newly insured adults may be more sensitive to price than their previously insured counterparts, even with the availability of financial assistance for coverage. Notably, more than half (56%) of newly insured Marketplace enrollees say they chose their plan primarily based on cost (data not shown).

Figure 22

**Main Reason for Choosing Health Plan, Among Low- and Middle- Income Insured Adults Who Had a Choice**



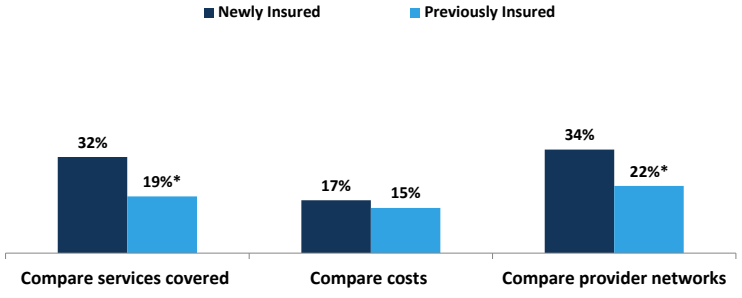

NOTE: Among insured adults ages 19-64 who had a choice of plans and made the choice themselves. "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014; some of these people may have switched coverage type. "Newly Insured" include people who were insured as of interview date and gained coverage since January 2014. *Significantly different from newly insured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

**Newly insured adults were more likely to say they had difficulty comparing services and provider networks across plans than previously insured adults.** In contrast to comparing costs, which similar shares of the newly insured (17%) and previously insured (15%) said was difficult, newly insured adults who chose a plan were significantly more likely than previously insured to say they found it difficult to compare services (32% versus 19%) or provider networks (34% versus 22%) (Figure 23). Comparing the newly insured and previously insured by coverage type, it appears that these differences may be linked to coverage type. For example, newly insured adults with Marketplace coverage were no more likely to report difficulty than the previously insured with Marketplace coverage (data not shown).

Figure 23

**Views of Plan Selection Process Among Low- and Middle-Income Adults Who Chose a Health Plan**

*Share reporting it was "somewhat difficult" or "very difficult" to:*

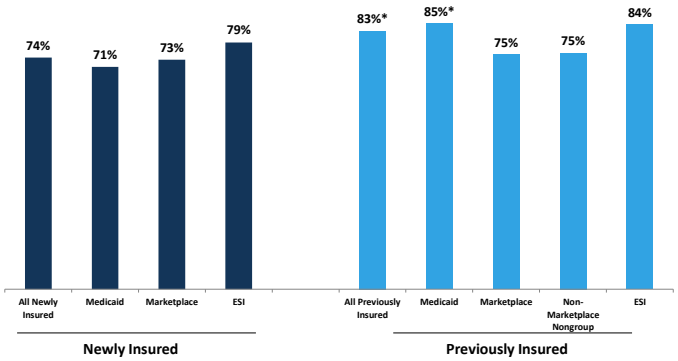



NOTE: "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014; some of these people may have switched coverage type. "Newly Insured" include people who were insured as of interview date and gained coverage since January 2014. *Significantly different from newly insured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

**Most newly insured adults give their health plan high ratings, but some report not understanding the details of their plan.** Nearly three quarters (74%) of all newly insured adults rate their coverage as "excellent" or "good" (versus "not so good" or "poor"), and this rate did not differ significantly by type of coverage that people gained (Figure 24). While these findings show high rates of satisfaction, adults who had coverage before 2014 were more likely to give their plan a high rating, with 83% saying their coverage was excellent or good.

Figure 24

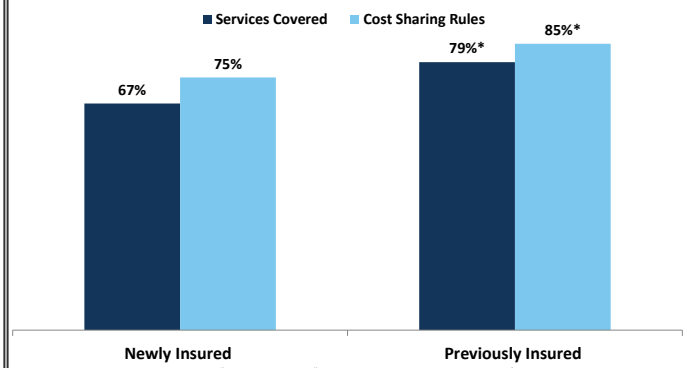
**Rating of Health Insurance Coverage among Low- and Middle-Income Insured Adults, by Insurance Coverage**




NOTE: Includes insured adults ages 19-64. "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014; some of these people may have switched coverage type. "Newly Insured" include people who were insured as of interview date and gained coverage since January 2014. * Significantly different from Newly Insured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

Figure 25

**Understanding of Health Insurance Coverage among Low- and Middle-Income Insured Adults, by Insurance Coverage**



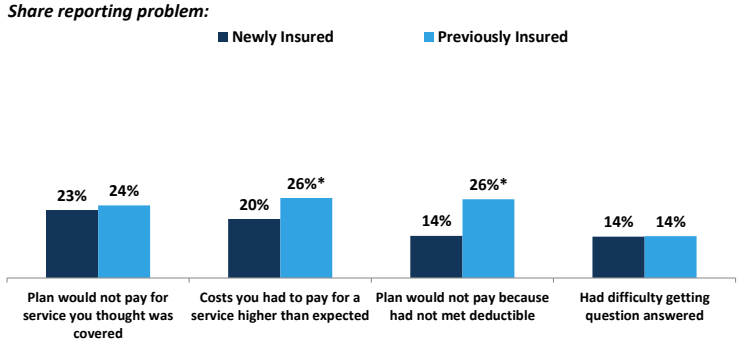

NOTE: Includes insured adults ages 19-64. "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014; some of these people may have switched coverage type. "Newly Insured" include people who were insured as of interview date and gained coverage since January 2014. * Significantly different from Newly Insured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

Lower plan ratings among the newly insured could reflect problems with coverage, but, as discussed below, newly insured were no more likely to report problems with their plans than their previously insured counterparts. However, newly insured adults were less likely than previously insured adults to say that they understand their plan (Figure 25). Just two thirds (67%) said they understand the services their plan covers "very well" or "somewhat well" (versus 79% of previously insured adults), and three quarters understand how much they would have to pay when they visit a health care provider (versus 85% of previously insured). These shares were not significantly different across coverage type within the newly insured. It is possible that newly insured adults face challenges in understanding the complexity of insurance coverage, and lower plan ratings could reflect confusion or misunderstanding about coverage.

**Newly insured adults were no more likely than previously insured to report a specific problem with their health plan.** When asked specifically if they encountered various problems with their coverage, such as coverage, costs, or customer service, newly insured adults reported similar or lower rates than previously insured. Specifically, there were no significant differences in shares reporting being denied coverage for a service they thought was covered or having difficulty getting a

Figure 26

**Problems with Current Coverage Among Low- and Middle-Income Insured Adults, by Insurance Coverage**




NOTE: Shares exclude those who say they had even but it was not a problem for them. "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014; some of these people may have switched coverage type. "Newly Insured" include people who were insured as of interview date and gained coverage since January 2014.
*Significantly different from newly insured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

question answered (Figure 26). Newly insured adults were less likely than previously insured to say they faced higher than expected out-of-pocket costs or that they had not yet met their deductible. Again, within the newly insured group, there were no significant differences in rates of problems by type of coverage, with the one exception of newly insured adults with employer coverage being less likely to say their plan did not cover a service they thought was covered. In addition, there were no consistent patterns in the share of newly insured adults reporting problems by when their coverage started.

## Policy Implications

As more and more evidence mounts to document coverage gains during the first year of the ACA, there is interest in understanding how these gains in coverage have affected the lives of the newly insured. Findings from the 2014 Kaiser Survey of Low-Income Americans and the ACA show, not surprisingly, that adults who gained coverage had better access to health care and better financial security from medical costs than those who remained without coverage. Still, comparison to adults who have had coverage since before 2014 show some areas for ongoing attention as policymakers strive to translate coverage to care.

**The ACA created new coverage options for people who were left out of coverage in the past.** Many people who gained coverage in 2014 were from groups that have historically lagged in access to health insurance, including part-time workers, single adults, and people of color. These groups had high uninsured rates in the past for a variety of reasons, including limited access to coverage through a job, limits on publicly-financed coverage, and low incomes that made affording coverage difficult. With the ACA, some of these barriers to coverage were eased. However, socio-demographic differences between the newly insured and remaining uninsured do reveal some remaining barriers to coverage. For example, the newly insured population is more likely than the remaining uninsured to be female—perhaps indicating a need for more outreach to men—and is more likely to be US citizens or legal immigrants—indicating ongoing restrictions to coverage for some immigrants. Further, while many who gained coverage in 2014 were people of color, indicating advances in addressing longstanding racial and ethnic disparities in health coverage, most of the remaining uninsured are people of color, with more than a quarter identifying as Hispanic. Continued expansion of coverage may be key to further efforts to address ongoing disparities in coverage.

**There is limited evidence of selection or a "surge" among newly insured adults.** Newly insured adults were no more likely than those who remained without coverage to be older or in poor physical or mental health. In fact, the newly insured adult population reports *better* health on average than the remaining uninsured population. In addition, compared to those who had coverage since before 2014, there were no differences in self-reported health status, and newly insured adults were less likely to have used medical services. The differences in utilization patterns between the newly insured and previously insured partially reflect the shorter period of time that the newly insured had their coverage, since most people's coverage started at least several months into 2014. Notably, newly insured adults were no more likely to use emergency care than those who had coverage since before 2014.

**Newly insured adults have protection from medical costs but still face some financial difficulty.** Compared to their counterparts who remained uninsured, adults who gained coverage in 2014 had better protection from medical bills and less worry about future medical costs. However, newly insured adults still face financial insecurity: they are more likely than those who had coverage before 2014 to worry about future

medical bills, and they face general financial insecurity at rates similar to the uninsured. Notable shares of both newly insured and previously insured adults report problems paying their monthly premium, and newly insured adults were particularly cost-sensitive in choosing their health plan. These patterns may indicate that while coverage can ameliorate some of the financial challenges that low- and moderate-income adults face, many will continue to face financial challenges in other areas of their lives.

**Coverage facilitates access to care, but some newly insured adults need additional support in navigating the health system and getting linked to care.** Like outcomes related to medical costs, survey results show that newly insured adults fared better than uninsured adults in access to care, including having a regular provider, receiving preventive care, not postponing care, and have effective communication with their provider. However, on some measures, newly insured adults reported more problems than their counterparts who have had coverage since before 2014: for example, they were less likely to have a regular provider, more likely to not get needed care, and more likely to say a provider would not take them as a patient due to insurance. These differences likely reflect a range of factors, including limited networks, problems navigating the health system, misunderstanding about how to use coverage and when to seek care, or concerns about out-of-pocket costs. While coverage facilitates access to care, it may not automatically or immediately link newly insured adults into care in the same way that adults who have had insurance for quite some time are. Ongoing monitoring of newly insured adults' access and utilization is important to assess whether this population continues to face challenges or whether these differences subside over time.

**Among the newly insured population, there were few differences in outcomes by type of coverage.** The ACA builds on the existing employer-based system to create coverage options for people across the income spectrum, including Medicaid (for people at the lowest incomes) and subsidies for Marketplace coverage (for people with middle-income). Medicaid is designed to serve a low-income population, with very limited cost sharing and broad benefits; Marketplace coverage is designed to serve those with middle incomes, with premium and cost-sharing support for people with income at the lower range of eligibility. Through some have expressed concern that some gaining coverage under the ACA are required to enroll in Medicaid versus Marketplace coverage, survey findings indicate very few differences in outcomes for these two groups. For example, there were no differences in plan ratings or problems with coverage, protection from medical bills, or access to care. The differences that were seen (for example, that newly insured adults with Medicaid are sicker, less likely to be in a working family, and are more generally financially insecure) largely reflect Medicaid's role in targeting lowest income and most vulnerable. However, on measures of how coverage works for enrollees, Medicaid and Marketplace coverage fared about equally well and generally as well as employer-based coverage.

## Appendix Table 1: Newly Insured, Previously Insured, and Uninsured Adults with Incomes Below 400% FPL, Fall 2014

| | Uninsured | | Newly Insured | Previously Insured | |
|---|---|---|---|---|---|
| ***Income*** | | | | | |
| ≤ 138% FPL | 59% | | 56% | 37% | * |
| 139 - 400% FPL | 41% | | 44% | 63% | * |
| ***Work Status*** | | | | | |
| Full Time Working Family | 47% | | 45% | 61% | * |
| Part Time Working Family | 19% | | 20% | 10% | * |
| Unemployed Family | 33% | | 33% | 29% | |
| ***Race/Ethnicity*** | | | | | |
| Hispanic | 31% | * | 23% | 18% | |
| White, Non-Hispanic | 45% | | 49% | 61% | * |
| Black, Non-Hispanic | 15% | | 19% | 12% | * |
| Other | 8% | | 9% | 9% | |
| ***Gender*** | | | | | |
| Female | 45% | * | 58% | 53% | |
| Male | 55% | * | 42% | 47% | |
| ***Citizenship*** | | | | | |
| Citizen | 77% | * | 87% | 94% | * |
| Legal Immigrant | 7% | | 7% | 3% | |
| Undocumented | 15% | * | 5% | 2% | * |
| ***Age*** | | | | | |
| 19-25 | 24% | | 19% | 18% | |
| 26-34 | 29% | | 31% | 20% | * |
| 35-44 | 20% | | 19% | 22% | |
| 45-64 | 26% | | 31% | 40% | * |
| ***Family Status*** | | | | | |
| Married with dependent children | 16% | | 16% | 29% | * |
| Married, no dependent children | 10% | | 11% | 18% | * |
| Not married with dependent children | 22% | | 22% | 14% | * |
| Not married, no dependent children | 52% | | 50% | 39% | * |
| ***Insurance Status of Participant's Children*** | | | | | |
| Doesn't have Children | 62% | | 62% | 57% | |
| All Children are insured | 25% | * | 35% | 41% | |
| Some or all children are uninsured | 12% | | -- | 2% | |
| ***Health Status*** | | | | | |
| Excellent/Good Health | 62% | * | 71% | 75% | |
| Fair/Poor Health | 37% | * | 28% | 25% | |
| Excellent/Good Mental Health | 79% | | 80% | 84% | |
| Fair/Poor Mental Health | 20% | | 18% | 16% | |
| Has Ongoing Condition | 32% | | 39% | 41% | |
| Taking Rx | 25% | * | 36% | 49% | * |
| ***Coverage Began In*** | | | | | |
| Quarter 1 | NA | | 40% | NA | |
| Quarter 2 | NA | | 20% | NA | |
| Quarter 3 | NA | | 22% | NA | |
| Quarter 4 | NA | | 9% | NA | |
| DK/RF | NA | | 9% | NA | |
| ***Prior Coverage*** | | | | | |
| Coverage started prior to 2014 | NA | | NA | 87% | |
| Had same plan, but renewed in 2014 | NA | | NA | 11% | |
| Had other plan, same coverage type | NA | | NA | -- | |
| Had other type of coverage | NA | | NA | 13% | |

Notes: NA: Not applicable. "--": Estimates with relative standard errors greater than 30% or with cell sizes less than 100 are not provided. * Estimate statistically significantly different from newly insured estimate at the 95% confidence level. Source: 2014 Kaiser Survey of Low-Income Americans and the ACA.

# ENDNOTES

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# Lessons from the Frontlines: Strategies for Supporting Informed Consumer Decision-Making in the Health Insurance Marketplace

**JUNE 2015**

national partnership for women & families

# Contents



**About the National Partnership for Women & Families**

At the National Partnership for Women & Families, we believe that actions speak louder than words, and for more than four decades we have fought for every major policy advance that has helped women and families.

Today, we promote fairness in the workplace, reproductive health and rights, access to quality, affordable health care, and policies that help women and men meet the dual demands of their jobs and families. Our goal is to create a society that is fair and just, where nobody has to experience discrimination, all workplaces are family friendly, and no family is without quality, affordable health care and real economic security.

Founded in 1971 as the Women's Legal Defense Fund, the National Partnership for Women & Families is a nonprofit, nonpartisan 501(c)3 organization located in Washington, D.C.

# Lessons from the Frontlines: Strategies for Supporting Informed Consumer Decision-Making in the Health Insurance Marketplace

**JUNE 2015**

# Executive Summary

Roughly 16.4 million people have gained health coverage in the five years since passage of the Affordable Care Act (ACA), and more than 11 million signed up for marketplace plans during the second open enrollment period alone.[1, 2]

As consumers gain familiarity with their health coverage, they are increasingly looking for help selecting plans that align with their financial circumstances and health care needs. In response, policymakers are working to improve the accessibility and transparency of information on key plan features and to develop consumer-friendly tools that make it easier to compare and select health plans.

In light of growing interest in how best to support consumer decision-making in the marketplace, this qualitative analysis offers recommendations for improving plan comparison and selection processes. Designed to complement "Supporting Informed Decision-Making in the Health Insurance Marketplace: A Progress Report,"[3] an analysis of the online plan selection tools that were available to marketplace consumers during the 2015 open enrollment period, this new report provides insight into Navigators' experiences helping consumers with enrollment. Under the ACA, Navigators are entities that are certified to help consumers choose coverage and enroll in Marketplace plans.[4] They have extensive experience with how consumers select plans and can offer insights from the frontlines on how to improve plan comparison and selection processes. This new report is based on interviews with national consumer assistance experts and Navigators in California, Colorado, Florida and Illinois conducted by Manatt Health in the spring of 2015.

## Key Findings

Consumers – and particularly those who already have experience with marketplace plans – are eager for more help selecting health coverage. They want to be able to identify the plans that cover their preferred providers and prescription drugs, and that protect them from excess out-of-pocket costs. Interviews with Navigators and national experts suggest that the following will help consumers identify the marketplace plans that best meet their health care needs and align with their financial circumstances.

- **Policymakers and marketplace officials should continue working to improve consumer health literacy.** After two open enrollment periods, Navigators still report that when they sit down with consumers to review plan options, they often must "back up" and provide basic information on what health insurance is and how it works. In light of this, policymakers and marketplace officials should continue to develop and share creative materials to enhance consumer health literacy. Such tools should be integrated into the plan selection process.

- **Policymakers and marketplace officials should continue to promote the development and application of tools that simplify and streamline plan comparison and selection.** The Navigators interviewed in this study reported that plan analysis and comparison is the most complicated and time-consuming part of their appointments with consumers. To simplify the plan comparison and selection process, policymakers and marketplace officials should improve and/or develop and utilize four critical tools:

    - **Summary of Benefits and Coverage Template:** A tool that enables consumers to compare plans across standardized plan elements, including benefit design and cost-sharing structuring.
    - **Integrated Provider Directory:** A tool that enables consumers to enter the names of their providers and then see which plan(s) include those preferred providers in-network.
    - **Integrated Prescription Drug Directory:** A tool that allows consumers to enter the names and dosage levels of their prescription drugs and then see which plan(s) cover those medications.
    - **Out-of-Pocket Cost Calculator:** A tool that enables consumers to estimate their annual out-of-pocket costs under different plans, based on anticipated health care usage.

- **Policymakers should work to ensure that health plan information presented in the marketplace is accurate and reliable.** Navigators report that consumers are sometimes presented with inaccurate or out-of-date plan information, particularly with respect to which providers are in-network and which prescription drugs are covered. Since accurate and reliable data is critical to informed consumer decision-making, policymakers and health plans should work together to ensure that health plan information is accurate and updated regularly.

## Looking Ahead

As the third open enrollment period approaches, marketplaces are well-positioned to strengthen and improve the tools and resources offered to consumers to support informed decision-making with regard to plan selection. Policymakers and marketplace officials should consider the insights of Navigators, who can offer a frontline perspective on how well plan comparison and selection processes have worked to date and how they can be improved. A detailed set of recommendations that emerged from this analysis is provided in the body of this report. A summary of these recommendations is included at the end.

# Introduction

Roughly 16.4 million people have gained health coverage in the five years since passage of the Affordable Care Act (ACA).[5] During the second open enrollment period alone, more than 11 million people signed up or were automatically enrolled in marketplace plans.[6]

As marketplaces prepare for the third open enrollment period, consumers are increasingly invested in selecting plans that meet their health care needs and align with their financial realities. Consumers recognize that their choice of plans can directly affect their access to providers, ability to afford prescription drugs and out-of-pocket spending. Thus, there is growing demand among consumers for information and tools that will help them evaluate plan options. In response, policymakers and marketplace officials are seeking to enhance consumer access to information on health plan features, particularly concerning provider participation in plan networks, cost-sharing charges and coverage of prescription drugs.

This report is intended to complement and build upon the National Partnership for Women & Families' earlier analysis of online plan comparison and selection tools available to marketplace consumers during the 2015 open enrollment period, "Supporting Informed Decision-Making in the Health Insurance Marketplace: A Progress Report."[7] It is based on interviews with Navigators and national experts. Under the ACA, Navigators are entities that are certified to help consumers apply for and choose coverage; provide fair and impartial information on marketplace plan options, premium tax credits and cost sharing reductions; facilitate enrollment in marketplace plans; and conduct public education activities to raise awareness of coverage options.[8] Navigators have been helping consumers select health plans during the last two open enrollment periods and have extensive experience with how consumers use plan comparison and selection tools.

By focusing on the insights of Navigators, this new analysis offers a frontline perspective on ways to improve the plan comparison and selection experience for consumers. It is a qualitative analysis that assesses, from the perspective of Navigators, how certain tools, including some identified in the National Partnership's previous report, are helping consumers compare and select plans. It also offers recommendations for improvement.

Drawing on Navigators' experiences, this analysis identifies three key pathways for supporting informed consumer decision-making in the marketplace: (1) supporting improved consumer health literacy; (2) developing and applying tools that simplify and streamline plan comparison and selection; and (3) ensuring health plan information is accurate and reliable. These key pathways and accompanying recommendations are detailed throughout the remainder of this report. A summary of key recommendations is included at the end.

# Methodology-In-Brief

To gauge Navigators' perceptions of how consumers are selecting plans and the effectiveness of key comparison and selection tools made available to consumers, Manatt Health conducted interviews with national consumer assistance experts and Navigators who work directly with consumers in California, Colorado, Florida and Illinois during the spring of 2015.

Interviewees were asked to provide insight into consumers' priorities for and their approaches to plan selection; the availability and effectiveness of plan comparison and selection tools; and recommendations for how to improve consumers' plan comparison and selection experiences.[9]

Drawing from these interviews, this analysis sought to evaluate Navigator experience in states operating state-run marketplaces (California and Colorado) and states that rely on Healthcare.gov as their marketplace (Florida and Illinois). Three of the four states were selected because they have developed particular consumer-targeted online tools to support plan comparison and selection, such as smart sort tools that display plan options based on a consumer's estimated annual health care costs (California); integrated provider directories and integrated prescription drug directories (Colorado); and a health plan comparison tool that allows consumers to compare plans across a number of factors, including total estimated costs and provider participation (Illinois). Given that such tools were identified as promising practices in the first National Partnership report, this new analysis sought to assess, from the perspective of Navigators, how well these tools are working for consumers.

# Navigator Perspectives on Consumer Experience with Health Plan Information and Plan Comparison and Selection Tools

Based on interviews with consumer assistance experts and Navigators, this analysis found that consumers, particularly those who already have experience in the marketplace, are eager for help comparing and selecting health plans.

Consumers want help identifying plans that cover their providers and prescription drugs, and that protect them from excess out-of-pocket costs. For consumers, the process of sorting through and comparing plan options remains time-intensive and complex, particularly when decision-making tools are not integrated into the plan comparison and selection process. Navigators say health literacy aides and plan comparison and selection tools have proven to be enormously helpful to consumers. Strengthening these tools and applying them to all marketplace websites will greatly improve consumers' experiences during future enrollment periods.

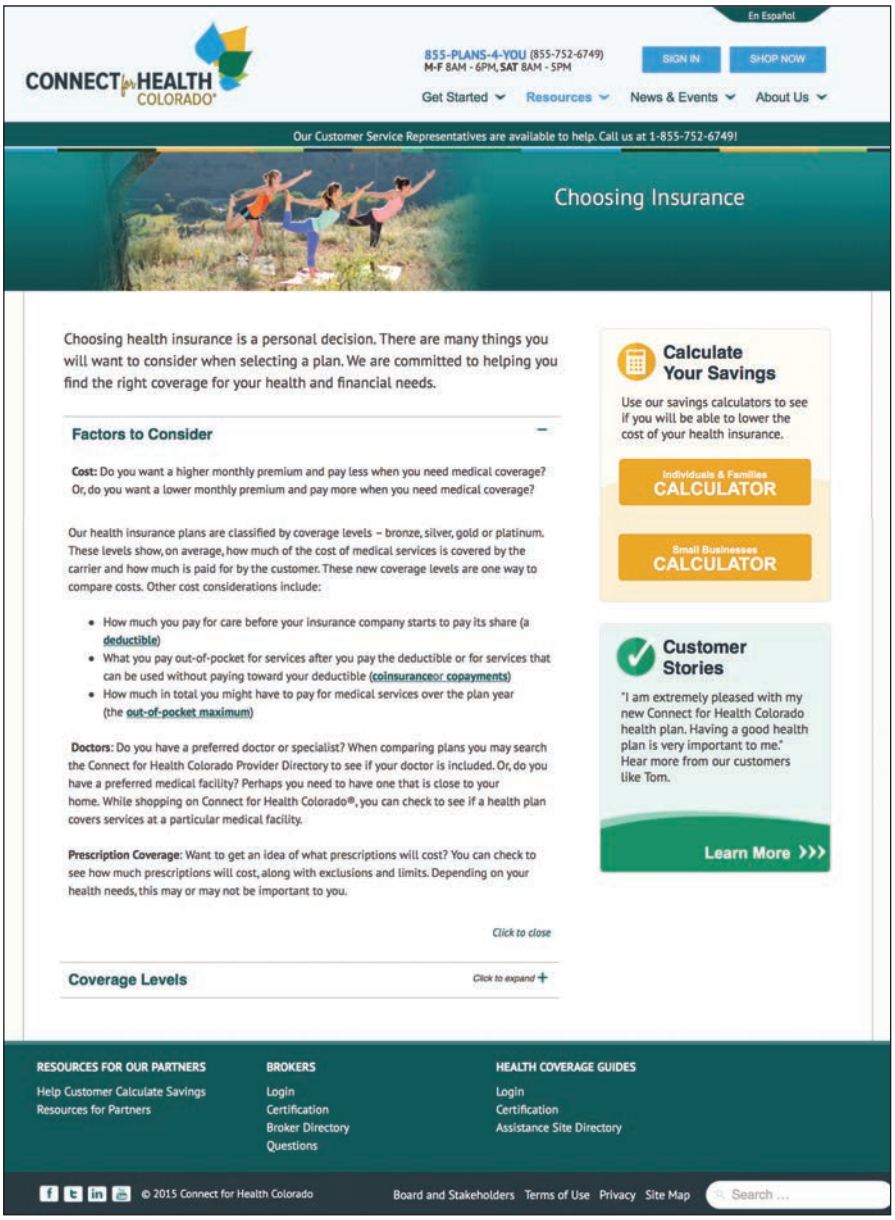
Navigators and national experts interviewed for this report identified the following key pathways for supporting informed consumer decision-making in the marketplace: (1) supporting improved consumer health literacy; (2) developing and applying tools that simplify and streamline plan comparison and selection; and (3) ensuring health plan information is accurate and reliable. These key pathways are discussed in detail below.

## Supporting Improved Consumer Health Literacy

Prior to the launch of the ACA marketplaces, many consumers targeted for marketplace enrollment were not confident that they understood important health insurance terms.[10] Navigators still identify low consumer health literacy levels as an additional challenge to already complex plan comparison and selection processes. When Navigators sit down with consumers to review plan options, they often must "back up" and provide consumers with basic information on what health insurance is and how it works.

A number of Navigators reported that they have developed tailored strategies for addressing health literacy issues. For example, some have developed informal "checklists" of items that consumers should consider when selecting plans, such as cost, inclusive of the premium and the deductible, and whether preferred physicians and prescriptions are covered. See Figure 1, which captures a page on the Connect for Health Colorado marketplace website that outlines important considerations for consumers and defines health insurance terms.

**Figure 1. Connect for Health Colorado Resource on Key Factors to Consider When Choosing Health Insurance**

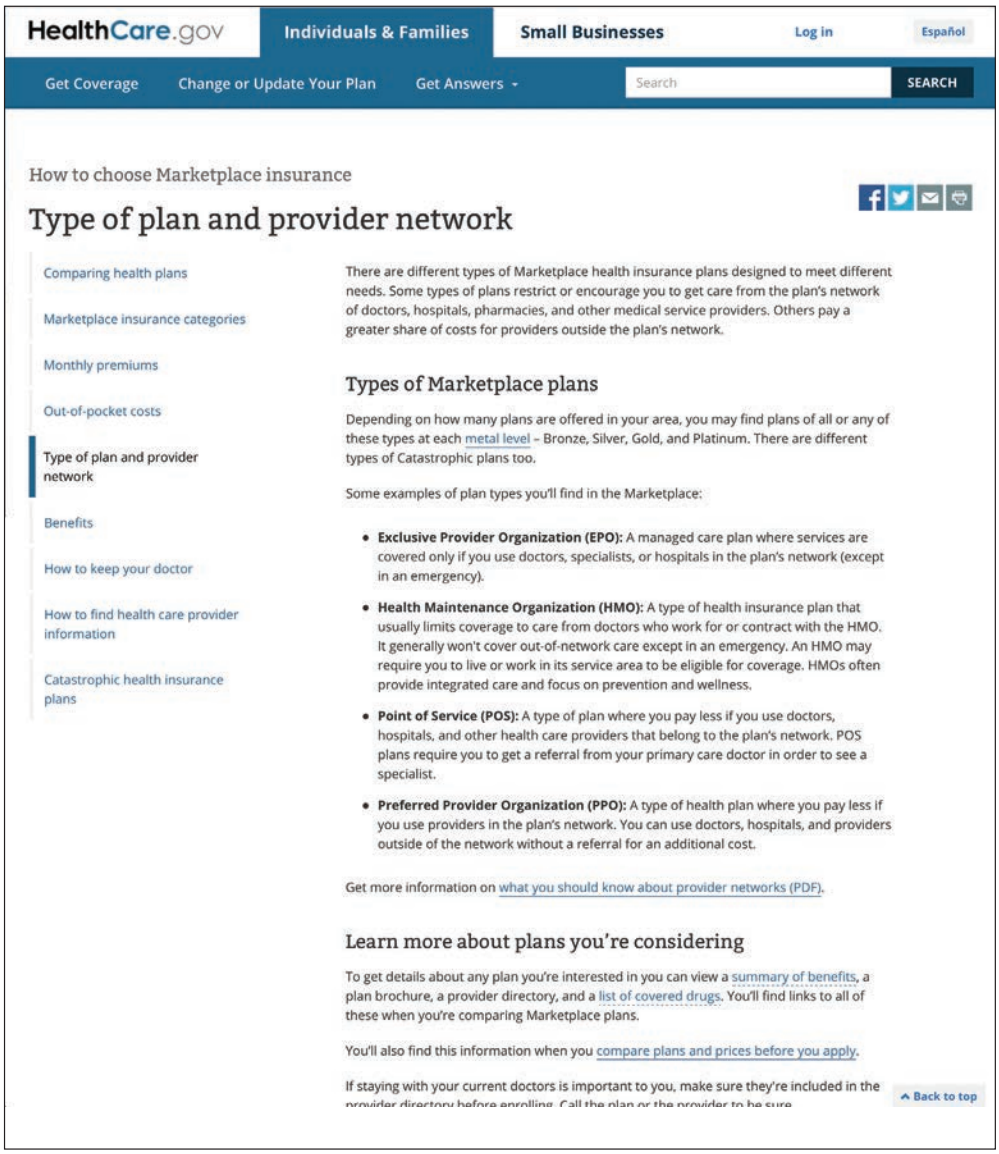



*Source: Connect for Health Colorado*

The federal government also has sought to improve consumer health literacy by developing and promoting materials that explain key health care and health insurance terms and offer information on how health plans work.[11] As part of the "Coverage to Care" initiative, the Centers for Medicare & Medicaid Services (CMS) has published consumer-friendly videos and resources that define key terms and offer advice on plan selection. As CMS continues to build on the "Coverage to Care" initiative and promote health literacy, its initiatives could be strengthened through greater integration into the marketplace plan comparison and selection process. Navigators reported that while the "Coverage to Care" materials are useful and provide a strong base for consumer education, few consumers are willing to read or watch such materials unless they are integrated into the real-time plan shopping experience and "pop up" as they go through the process. As one Navigator noted, consumer communications need to consider "when the information is delivered, from which messenger and how it is reinforced."

For example, Healthcare.gov offers a comprehensive checklist for consumers to review before entering the plan browsing experience, as shown in Figure 2, below.[12] Additional promising practices include the use of "hover mechanisms" and marketplace avatars. Hover mechanisms define key terms for consumers throughout the browsing experience: When a consumer places the cursor over a key term on a marketplace website, a pop-up definition for that term appears. Hover mechanisms are currently utilized by marketplace websites in Connecticut, New York and Washington. Similarly, avatars help define key terms and help consumers navigate the marketplace website. The marketplace websites for Connecticut and Colorado currently employ avatars to help consumers throughout the plan browsing experience.

**Figure 2. Healthcare.gov Resource on Different Types of Health Insurance Plans**




*Source: Healthcare.gov*

**RECOMMENDATIONS:**

- **Continue to develop and share creative materials and tools to improve consumer health literacy, and integrate these tools into the plan comparison and selection process.**

  Policymakers and marketplace officials should leverage existing health literacy materials and continue finding creative, interactive and visual ways to explain information to consumers. Information should be provided to consumers when they need it in real-time, both during the plan comparison and shopping experience and throughout the year when they seek health care services. Amongst other key elements, health literacy materials should address, in multiple languages other than English, the following information:

  - Factors each consumer should consider when selecting a plan, such as covered services; the total cost of the plan, inclusive of the premium, deductible and other cost-sharing charges; whether preferred physicians are in-network; and whether prescriptions are covered by the plan.
  - Definitions of key health care and health insurance terms, such as premium, copayment, coinsurance, deductible and out-of-pocket maximum.
  - Guidance on how to review and use a provider directory.
  - Guidance on how to review and use a prescription drug formulary.
  - Definitions of and differences between plan products and provider network models.
  - Information about how to use health care coverage, similar to the step-by-step instructions on how to fill prescription medications and access medical care provided in the "Using your new Marketplace health coverage" section on Healthcare.gov.[13]

  Policymakers and marketplace officials should work with consumer advocacy organizations, organizations representing minority populations, Navigators and others to identify how best to deliver information, integrate health literacy tools into the plan selection and comparison process and reinforce educational information throughout the year.

- **Provide consumers with a checklist of information they should have on hand prior to shopping for a plan.**

  All marketplace websites should provide consumers with a checklist of information to have on hand before they begin the plan comparison and selection process. This should include, at minimum, income and citizenship information, the names and addresses of their current providers and a list of health care services and prescription medications they may need. Interview subjects noted that it is important for consumers to gather such information prior to beginning the plan shopping experience.

## Developing and Applying Tools That Simplify and Streamline Plan Comparison and Selection

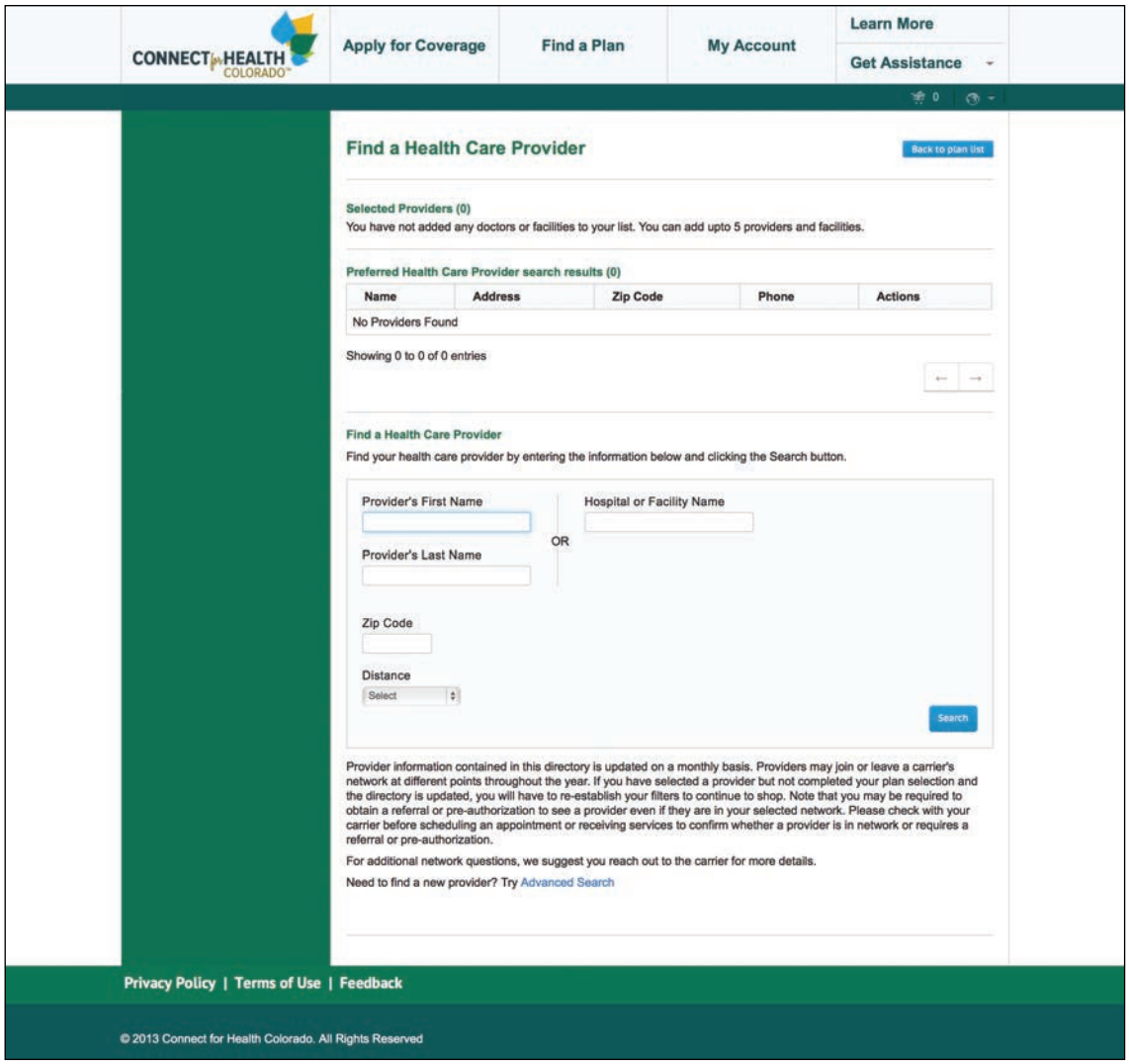
Navigators reported that, during the 2015 open enrollment period, plan comparison was the most complicated and time-consuming part of assisting consumers with enrollment. Navigators often sit with consumers with a pencil, paper and a calculator in order to determine which plans cover preferred providers and prescription medications, and to estimate what the consumer's annual out-of-pocket costs may be under various health plans.

Navigators in states with a large number of participating qualified health plans (QHP) reported that sorting through plan options was time-intensive and that Navigators often have time to review only a few plans with consumers during appointments. One Navigator said it could take a full hour to review just three plans, describing the plan comparison and selection process this way: If a consumer wants to understand out-of-pocket costs, the Navigator uses a calculator to help the consumer estimate how much he or she will spend given a plan's premium, deductible and cost-sharing structure and the individual's personal medical circumstances. The Navigator then helps the consumer "click through" to a plan's provider directory to see if the consumer's preferred providers and facilities are in the plan's network. If the consumer requires particular medications, the Navigator "clicks through" to the plan's formulary to ascertain whether the plan covers those prescriptions. The Navigator noted, "It's like puzzle pieces – you have to put together all of the pieces to figure out what will be best for the consumer."

To meet consumer demand for enhanced comparison tools, a growing number of advocacy groups, provider networks and others are producing tools that identify or recommend specific plans that work well for consumers with particular situations or health conditions. For example, one Navigator reported that many of her clients with cancer arrive with a "cheat sheet" that identifies the plans that have been recommended by a local cancer center because those plans include the facility in-network and cover many medications required by cancer patients.

Additionally, states are piloting promising plan comparison and selection tools.[14] In many instances, Navigators had experience with plan selection tools available in their state's marketplace, such as an integrated provider directory and prescription drug directory (Colorado; see Figure 3), a "smart sort" tool (California) and a Marketplace Health Plan Comparison Tool (Illinois). Navigators in Colorado reported that the integrated provider and prescription drug directories were particularly helpful, greatly simplifying consumers' ability to identify which plans included their preferred providers in-network and which covered their medications. These Navigators had recommendations for how the tools could be improved; in one case, for instance, by enabling the integrated provider directory to identify plans that include multiple preferred providers in-network. (Currently, the tool only allows consumers to search one provider at a time.) Navigators also recommended that the tool be enhanced to alert consumers to differences in cost-sharing obligations for primary care providers versus specialists and between tiers of primary care doctors.

**Figure 3. Connect for Health Colorado's Integrated Provider Directory**

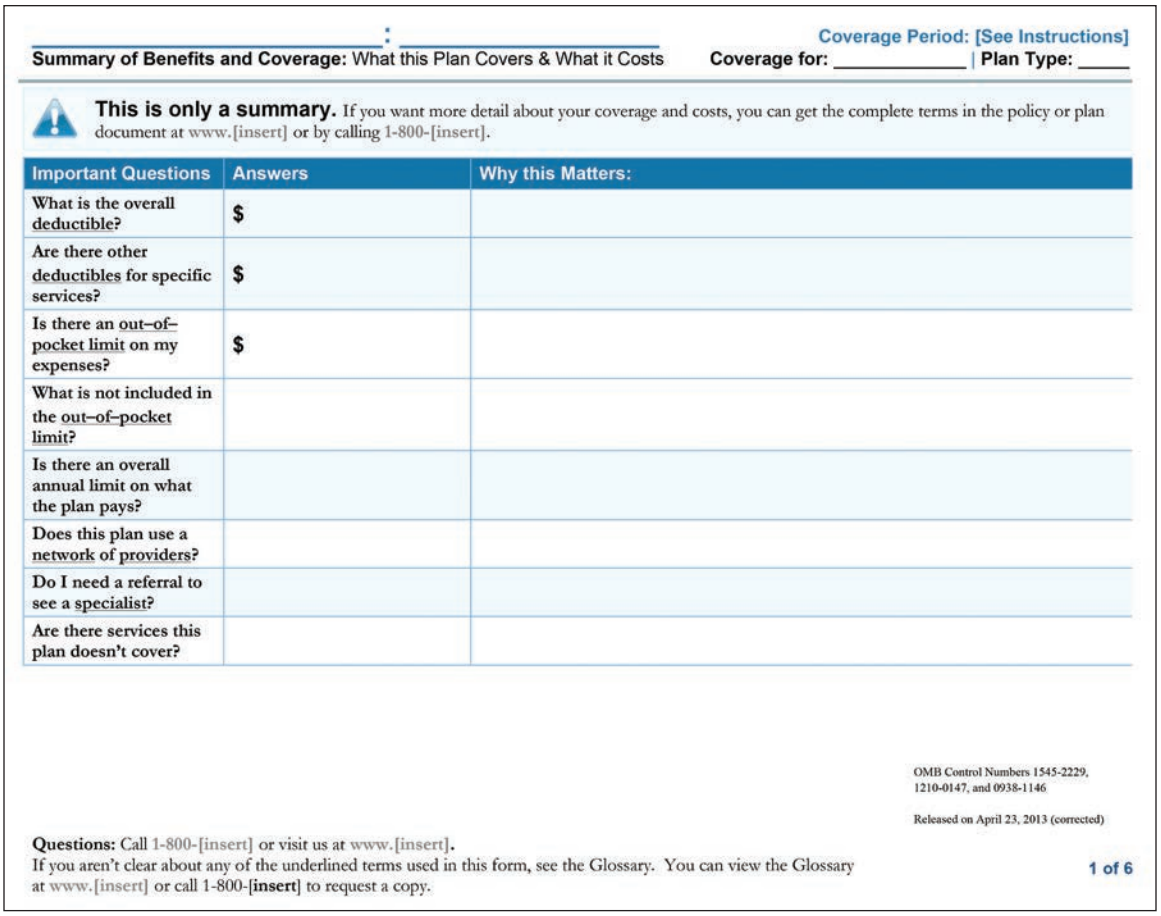



*Source: Connect for Health Colorado*

In Illinois, Navigators saw value in the Marketplace Health Plan Comparison Tool, which offers consumers an estimate of annual out-of-pocket costs for a plan. They reported that the tool greatly simplifies the challenge of figuring out how much consumers might spend under a given plan based on their particular health care needs. One suggestion for improvement was to modify the tool to query consumers about prescription drug use. (Currently, the Marketplace Health Plan Comparison Tool does not ask consumers for information on prescription medications and therefore may not adequately estimate a consumer's out-of-pocket costs.)

Federal policymakers are in the midst of major efforts to provide consumers with improved plan selection tools, including a more comprehensive Summary of Benefits and Coverage (SBC) template (see Figure 4), enhanced provider and prescription drug directories and out-of-pocket cost calculation tools. Designed to allow consumers to compare plans across standardized elements, the SBC presents information about a plan's benefit design, including key covered health care services and cost-sharing obligations associated with those services. The ACA requires all issuers to make an SBC available to consumers. While Navigators reported that the SBC template is a helpful tool, they identified a number of ways it could be improved. Consumer advocates, too, have recommended improvements. For example, Navigators and consumer advocates agree that, from reviewing the SBC template alone, it can be difficult to determine which health care services are subject to the plan's deductible. Consumers also have difficulty discerning from the current SBC template whether important services and prescription drugs, such as specific birth control procedures and products, are covered by the plan.

**Figure 4. Summary of Benefits and Coverage (SBC) Template**



_____: _____
**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

Coverage Period: [See Instructions]
**Coverage for:** _____ | **Plan Type:** _____

**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.[insert] or by calling 1-800-[insert].

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| What is the overall deductible? | $ | |
| Are there other deductibles for specific services? | $ | |
| Is there an out–of–pocket limit on my expenses? | $ | |
| What is not included in the out–of–pocket limit? | | |
| Is there an overall annual limit on what the plan pays? | | |
| Does this plan use a network of providers? | | |
| Do I need a referral to see a specialist? | | |
| Are there services this plan doesn't cover? | | |

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Released on April 23, 2013 (corrected)

**Questions:** Call 1-800-[insert] or visit us at www.[insert].
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.[insert] or call 1-800-**[insert]** to request a copy.

1 of 6

*Source: CMS.gov*

To address consumer concerns, in December 2014 the Internal Revenue Service (IRS), the U.S. Department of Health and Human Services (HHS) and the U.S. Department of Labor (DOL) proposed regulatory changes to the SBC that include revisions to its template, to instructions for completing it and to its uniform glossary of terms.[15] Final regulations concerning the SBC were published on June 16, 2015.[16] As per the final rule, a finalized updated SBC template and associated documents should be issued by January 2016 and will apply to plan years beginning in 2017.[17]

In addition to improvements to the SBC, federal policymakers have demonstrated intent to improve consumer ability to compare plan options based on plans' provider networks, prescription drug formularies and out-of-pocket costs. In February 2015, HHS issued a final rule[18] requiring QHP issuers to publish up-to-date, accurate and complete provider directory and formulary information. This information must be updated at least monthly and submitted to HHS in a machine-readable format. HHS has also published a Request for Information (RFI) to explore development of a tool that provides consumers with out-of-pocket cost estimates.[19] At the time of publication, HHS is currently accepting comments on a proposed out-of-pocket cost estimates tool and options for incorporating such a tool into Healthcare.gov.[20]

These developments signal important progress in providing greater support for consumers who are comparing and selecting plans. Both Healthcare.gov and state-run marketplaces must continue to improve the plan comparison and selection process and provide consumers with the tools they need to make informed enrollment choices.

**RECOMMENDATIONS:**

- **Continue to improve and develop tools that allow consumers to compare plans across key dimensions.**

  There are four fundamental tools that marketplaces should continue to develop and improve that would support more informed consumer decision-making: (1) the SBC template; (2) an integrated provider directory; (3) an integrated prescription drug directory; and (4) an out-of-pocket cost calculator. These tools should be easily accessible and integrated into the plan selection process. In addition, consumers should find the tools easy to use and should be able to easily revise and filter search criteria.

  **Summary of Benefits and Coverage Template.** The SBC template should be revised to be more consumer-friendly. Recommendations for improvement include:

  - Further simplify the key health care terms it uses.
  - Modify the template to clearly identify preventive services and their exemption from cost-sharing obligations.
  - Provide greater clarity with respect to which services are subject to the plan's deductible.
  - If a plan has multiple deductibles, provide clear explanations of how its deductibles interact with one another (e.g., the relationship between a medical deductible and a prescription drug deductible).
  - Provide greater clarity about how a deductible applies to an individual plan versus to a family plan, and about the different types of family deductibles and how they apply.

- Put greater emphasis on the implications of accessing services out-of-network.
- Include additional coverage examples, such as for a simple injury or for a catastrophic event, and estimates for how much a consumer can expect to spend in those scenarios.

**Integrated Provider Directory.** Integrated provider directories should allow consumers to enter the names of their providers and quickly identify which plan(s) include those providers in-network. They should include the following features:

- Ability to enter several preferred providers into one search and to identify plans that cover all or a subset of searched providers.
- Permit searches to be conducted for the following criteria, using a drop-down menu and/or a free text search field:
  - In-network hospitals
  - In-network provider practices
  - In-network facilities
  - Provider type (e.g., family medicine, allergist)
  - Distance (e.g., based on the consumer's residential ZIP code, county, other)
- Alert consumers to cost-sharing obligations that apply to particular providers or facilities if the plan tiers in-network providers and facilities.

**Integrated Prescription Drug Directory.** Integrated prescription drug directories should allow consumers to enter the names of their prescription drugs and quickly identify which plan(s) cover them. Integrated prescription drug directories should include the following features:

- Ability to enter several prescription drugs into one search and to identify plans that cover all or a subset of searched prescription drugs. The search results should clearly specify which plans cover which medications.
- Ability to enter medication dosage levels.
- Alert consumers to prescription drug tier-placement and cost-sharing obligations, including utilization management restrictions.
- Notify consumers if the plan covers a generic version of the searched prescription drug.
- Enable users to save a drug list in their Healthcare.gov or state-run marketplace website profile.

**Out-of-Pocket Cost Calculator.** Out-of-pocket cost calculators should allow consumers to estimate their annual out-of-pocket costs under different plans based on their anticipated health care and prescription drug usage. Out-of-pocket cost calculators should include the following features:

- Ability to synthesize and present information on all the costs a consumer might incur, including premiums, deductibles and cost-sharing charges.

- Ability for consumers to provide detailed information on their health status and the health care services and prescription drugs they expect to utilize during the plan year, including, for example:
  - Primary care provider office visits
  - Specialist office visits
  - Anticipated services
  - Categories of surgeries
  - Pregnancy and delivery
  - Common chronic conditions
  - Common illnesses, such as the flu
  - Prescription drugs
  - Income information
  - Eligibility for premium tax credits and cost-sharing reductions
- Ability for consumers to "customize" the amount of data they want to enter about their personal circumstances in order to secure estimates of out-of-pocket costs.
- Clear explanations that the tool is providing an estimate of out-of-pocket costs, and that a person's actual expenditures will depend on their actual health care usage during the plan year.
- Clear explanations of the tool's methodology and limitations.

## Ensuring Health Plan Information Is Accurate and Reliable

Navigators reported that the accuracy of plan information is critically important to consumers and raised concerns about the reliability of the plan information presented in the marketplace, particularly with regard to participating providers and covered prescription drugs. Navigators reported having worked with consumers who have selected a plan based on its provider directory, believing their preferred providers would be in-network only to learn after open enrollment closed that the provider no longer contracts with the plan. Navigators also reported similar, although less frequent, issues with respect to plans' prescription drug formularies. For now, Navigators are advising consumers to directly contact a provider prior to enrollment to confirm participation in a plan. They also routinely advise consumers with significant prescription drug needs to call an insurance carrier directly to verify whether their medications are included in a plan's formulary.

Navigators also flagged inconsistencies with how plan data is displayed across multiple information sources. For example, data on a plan's deductible and cost-sharing structure presented in its SBC template sometimes differs from how that same information is presented in the plan's underlying documents. In addition, how a plan is named in a marketplace website's anonymous browsing tool sometimes does not match how the plan is named on the issuer's website, making it difficult for consumers to contact the issuer for further information.

As noted above, recent federal regulatory action requiring plans to update provider directories and drug formularies monthly is an important step toward improving the accuracy of this data.[21] To ensure that consumers are accessing accurate and reliable plan information when they compare and select plans, marketplace officials should take additional measures as detailed below.

**RECOMMENDATIONS:**

- **Take specific steps to ensure plan information is complete, accurate and up-to-date.**

  Policymakers should require marketplaces to take, at minimum, the following steps to ensure that information is accurate and easily accessible:

  - Conduct occasional spot checks to assess the accuracy and reliability of plan data, including provider directories, prescription drug formularies and descriptions of out-of-pocket costs.
  - Establish procedures that consumers and Navigators can use to report issues with featured plan data. Consumers and Navigators should be able to report inaccuracies or problems to both the plan issuer and to the marketplace.
  - Provide consumers and Navigators with a specific process for securing additional information on plans, as needed (e.g., a dedicated call-in line).
  - Ensure that information provided by plans for marketplace summary platforms, such as the SBC or a "plan details" webpage, is consistent with the plan's underlying documents.
  - Provide clear disclaimers on "plan details" webpages and other relevant marketplace webpages that plan information is updated by plans continuously. Direct consumers to where they can learn when a plan last updated its data and provide guidance on how consumers can secure the most current information, if needed.
  - Hold QHP issuers accountable for reporting requirements set forth by federal and state policy.

# Conclusion

After two open enrollment periods, millions of consumers are enrolled in insurance plans through the ACA.

Increasingly, consumers in the marketplace are focused on selecting plans that align with their specific health care needs and financial circumstances. To help consumers select the plans that are best for them, marketplaces should continue to provide information and tools that help consumers compare and weigh their options.

A key support system for consumers comparing and selecting marketplace plans, Navigators provide valuable insights into the tools consumers are currently using, how those tools could be improved and what additional tools are needed. States, Healthcare.gov, Navigator organizations and public and private entities have taken important steps to synthesize information and provide tools that simplify and streamline plan comparison and selection. Even so, enrollment remains a time-consuming, complex and hugely challenging process for many consumers.

Additional health literacy materials, and in particular tools that are integrated into the plan shopping experience, would support informed consumer decision-making. Consumers also would benefit from enhanced tools that help them analyze and compare plans, such as integrated provider and prescription drug directories and out-of-pocket cost calculators. Policymakers should continuously refine these tools so they address diverse consumer needs and include customizable options. Such enhancements will especially benefit consumers with extensive or specific health care needs and their families. Finally, consumers need plan information to be accurate and up-to-date so that they can rely on this data to make informed decisions about the plans that are best for them and their families.

While great progress has been made over the first two open enrollment periods, advocates and policymakers must continue collaborating to develop and refine tools that will help consumers make informed decisions about the health plans that best meet their health care needs and financial circumstances. Only then can the promise of the health care marketplace be fully realized.

# Summary of Recommendations: Strategies for Improving Informed Consumer Decision-Making

## Support Improved Consumer Health Literacy

- **Continue to develop and share creative materials and tools to improve consumer health literacy and integrate these tools into the plan comparison and selection process.** Health literacy materials should include a list of factors to consider when selecting a plan; definitions of key health care terms; guidance on how to use a provider directory and review a prescription drug formulary; information on differences between plan products and provider network models; and direction on how to use health care coverage. Policymakers and marketplace officials should work with advocacy organizations, Navigators and others to identify how best to deliver this information, how to integrate health literacy tools into the plan selection process and how educational information can be reinforced throughout the year.

- **Provide consumers with a checklist of information they should have on hand prior to shopping for a plan.** Before beginning the plan comparison and selection process, all marketplace websites should provide consumers with a checklist of information to have on hand, such as income and citizenship information, the names and addresses of their current providers and a list of health care services and prescription medications they may need.

## Develop and Apply Tools That Simplify and Streamline Plan Comparison and Selection

- **Continue to improve and develop tools that allow consumers to compare plans across key dimensions.** There are four fundamental tools that marketplaces should continue to develop and improve that would support informed consumer decision-making: (1) the Summary of Benefits of Coverage (SBC) template; (2) an integrated provider directory; (3) an integrated prescription drug directory; and (4) an out-of-pocket cost calculator. These tools should be easily accessible and integrated into the plan shopping experience.

  **Summary of Benefits and Coverage Template.** The SBC template should be revised to be more consumer-friendly by further simplifying the terminology it uses and by providing information on the covered services consumers frequently ask about, such as preventive services. The SBC template should clearly explain a plan's cost-sharing structure and include information about when a service is subject to the deductible and how multiple deductibles may interact.

  **Integrated Provider Directory.** Integrated provider directories should allow consumers to enter the names of their providers and quickly identify which plan(s) include those providers in-network. They should be able to filter plans by multiple providers and by different types of providers. If a plan has different tiers of providers and facilities, the tool should alert consumers to the cost-sharing obligations that apply to a particular provider or facility.

**Integrated Prescription Drug Directory.** Integrated prescription drug directories should allow consumers to enter the names of their prescription drugs and quickly identify which plan(s) cover them. They should allow consumers to enter several prescription drugs into one search function and view which plans cover all or a subset of them. They should alert consumers to tier-placement and cost-sharing obligations, including utilization management restrictions, and notify consumers if a generic version of the drug is covered. Lastly, the tool should allow users to save drug lists in their Healthcare.gov or state-run marketplace website profiles.

**Out-of-Pocket Cost Calculator.** Out-of-pocket cost calculators should allow consumers to estimate their annual out-of-pocket costs under different plans based on their anticipated health care and prescription drug usage. They should be equipped to present information on the costs a consumer can expect to incur, based on his or her health status and expected utilization of services, including premiums, deductibles and cost-sharing charges. These tools should clearly explain their methodology and note that they are providing estimates of out-of-pocket costs, with actual expenditures dependent upon health care usage over the course of the plan year.

## Ensure That Health Plan Information Is Accurate and Reliable

- **Take specific steps to ensure plan information is complete, accurate and up-to-date.** At minimum, marketplaces should conduct occasional spot checks to assess the accuracy of plan information and establish procedures that consumers and Navigators can use to flag any inaccuracies or issues with plan data. Marketplaces should notify consumers that plan information is updated continuously and provide guidance on how consumers can access updated information. Policymakers and marketplaces must hold QHP issuers accountable for reporting requirements set forth in federal and state policy.

# Appendix A – Methodology for Interviews

Manatt Health conducted interviews with national experts and frontline Navigators during the spring of 2015 (March 17, 2015 to May 8, 2015).

The purpose of the interviews was to evaluate the strategies and tools that Navigators currently use to help consumers select plans that best meet their health care needs and financial circumstances, and to identify additional tools that would be helpful in supporting consumer decision-making. To identify current and promising plan selection practices, Manatt relied on the insights of a number of national consumer assistance experts and frontline Navigators in Florida, California, Colorado and Illinois (see Appendix B for a list of interviewees).

These four states were chosen because they represent both state-run marketplaces and states that use Healthcare.gov. Additionally, California was selected because it has a "smart sort" tool that allows consumers to rate medical and prescription drug utilization for each member of their family from low to very high. Based on the consumer's responses, the tool sorts plans by estimated annual health care costs, including premiums and out-of-pocket expenses. Colorado was selected because it has an integrated provider directory and prescription drug directory. Illinois was selected for its Marketplace Health Plan Comparison Tool, a Consumers' Checkbook product that compares plans across a number of factors including total estimated costs, plan quality and provider participation.

The following is a list of the interview questions that were the foundation for the interviews.

### CONSUMERS' PRIORITIES FOR AND APPROACH TO MARKETPLACE PLAN SELECTION

- How often do consumers look to you for assistance with marketplace plan selection? What role do you play in supporting their plan selection decision-making?
- How well do you think consumers understand their plan choices?
- What are the key factors that consumers tell you are important when they are trying to select marketplace plans (e.g., price, quality/effectiveness information, coverage of a particular drug/device, proximity to providers)?
- In general, how do consumers approach plan selection? For example, how often do they use the comparative information on websites versus relying on recommendations from friends and other strategies? How often do they pick one of the first plan options that is presented on the results page rather than engaging in further shopping?

### AVAILABILITY AND EFFECTIVENESS OF EXISTING PLAN SELECTION TOOLS AND STRATEGIES

- What tools do you find are the most useful in your efforts to support people in selecting plans? How much do you rely on marketplace websites? On other tools/sources of data?
- How readily can you find information on key features of marketplace plans for consumers, such as cost-sharing policies, benefits, provider networks and prescription drug policies?

- To what extent are you able to access and review plan formularies to determine whether consumers' prescription drugs are covered? What tools do you have and need to explain cost sharing to consumers?
- Are there tools that exist that you do not use and if so, why do you not use them?
- If you have had any experience with Medicare Part D selection, how do the tools available for this process compare to the tools provided on marketplace websites?

## RECOMMENDATIONS TO IMPROVE MARKETPLACE PLAN SELECTION EXPERIENCE

- From your perspective, what promising strategies/tools should be made available so that consumers and those assisting them can identify plans that are right for them given their health care and financial needs?

# Appendix B – Navigator and National Expert Interviewees

In order to understand how consumers are making plan selection decisions and the tools available to support consumer decision-making, in the spring of 2015 Manatt Health conducted a series of interviews with national consumer assistance experts and frontline Navigators who work directly with consumers in California, Colorado, Florida and Illinois. The following is a list of the interviewees.

## Navigators

### CALIFORNIA

- Griselda Vazquez, Outreach and Enrollment Coordinator, Livingston Community Health, April 16, 2015
- Jan Spencley, Executive Director, San Diegans for Healthcare Coverage, May 16, 2015

### COLORADO

- Eileen Hunt, Certified Enrollment Counselor, Broomfield County Health and Human Services, April 20, 2015

### FLORIDA

- Jodi Ray, Principal Investigator/Project Director, Florida Covering Kids & Families, April 2, 2015
- Karen Basha Egozi, Chief Executive Officer, Epilepsy Foundation of Florida, April 15, 2015

### ILLINOIS

- Jessica Palys, Navigator, Campaign for Better Health Care, April 23, 2015

## National Experts

- Lynn Quincy, Associate Director of Health Reform Policy, Consumers Union, April 16, 2015
- Karen Pollitz, Senior Fellow, Kaiser Family Foundation, April 14, 2015
- Kirsten Sloan, Senior Director of Policy Analysis and Legislative Support, and Anna Howard, Policy Principal, Access and Quality of Care, American Cancer Society Cancer Action Network, April 17, 2015
- Sophie Stern, Deputy Director, Best Practices Institute, Enroll America, May 8, 2015
- Mara Youdelman, Managing Attorney, National Health Law Program, March 17, 2015
- Amy Rosenthal, Director of External Affairs and Policy, Community Catalyst, March 17, 2015

# Endnotes


1 U.S. Department of Health and Human Services. (2015, May 5). *Health Insurance Coverage and the Affordable Care Act.* Retrieved 10 June 2015 from http://aspe.hhs.gov/health/reports/2015/uninsured_change/ib_uninsured_change.pdf

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ACA Implementation—Monitoring and Tracking

# Marketplace Price Competition in 2014 and 2015:

## Does Insurer Type Matter in Early Performance?

June 2015

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Robert Wood Johnson Foundation

URBAN INSTITUTE

With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act of 2010 (ACA). The project began in May 2011 and will take place over several years. The Urban Institute has been documenting changes to the implementation of national health reform to help states, researchers and policymakers learn from the process as it unfolds. Reports that have been prepared as part of this ongoing project can be found at **www.rwjf.org** and **www.healthpolicycenter.org**. The qualitative component of the project is producing analyses of the effects of the ACA on enrollment (including Medicaid expansion), insurance regulation and marketplace competition.

# INTRODUCTION

Nongroup health insurance premiums in the first two years of the Affordable Care Act's (ACA) insurance marketplaces were lower than anticipated in many areas.[1] Increases in insurers' lowest-cost silver plan premiums between 2014 and 2015 averaged 2.9 percent.[2] Previous analyses, however, have not focused on which types of participating insurers—some new to providing coverage in the private sector commercial markets—have been responsible for these outcomes. Many types of insurers, such as national insurers, regional insurers, Blue Cross Blue Shield insurers, previously Medicaid-only insurers (hereafter referred to as Medicaid insurers), provider-sponsored insurers, and co-ops, newly compete with each other in many areas. Accordingly, competition in many markets has been altered significantly relative to the preexisting nongroup markets.

Though individual insurers have their own cost structures, marketing approaches and pricing strategies, it is instructive to assess differences in how the different types of insurers are operating across the country. Doing so provides insight into the evolving nature of competition in nongroup insurance markets. These markets experienced little true price competition before the ACA's implementation because they were dominated by insurer competition for the most favorable risks when coverage denials and medical underwriting were permitted. The results reported here should provide context for changes in premium setting for the 2016 plan year.

We summarize the extent of participation and overall experience of each type of insurer in the nongroup marketplaces in 2014 and 2015 and then provide specific examples of their competitive positioning in particular areas.

# SUMMARY OF FINDINGS

The principal findings of our analysis of insurer participation and pricing in 73 rating regions in 30 states are as follows:

- National insurers, including Aetna/Coventry, United, Assurant, Cigna, and Humana and their subsidiaries were reluctant to participate in the marketplaces in the first year, but they entered many more markets in the second year. With the exception of Humana, they typically have higher than average premiums, continuing to reflect a significant aversion to risk.
- Regional insurers are also participating in a significant number of marketplaces, but many appear to be struggling to remain price competitive, although there are some prominent exceptions.
- Blue Cross insurers offer plans that rank among those with the lowest premiums in many markets, although this was more frequently the case in 2014 than in 2015. Depending upon the nature of the market, Blues insurers take very different pricing strategies. Some Blue Cross

### 2016 Plan Year Premiums

Though there have been reports that insurers are submitting requests for large nongroup insurance premium increases in 2016, the information available is both limited and preliminary.[3] Premium requests must go through rate review through state departments of insurance and such reviews can lead to lower increases than originally requested. In addition, much of the information released on premium increase requests has been limited to those insurers asking for large increases because the ACA requires that those requests exceeding 10 percent be validated with supporting data to be approved. Avalere's recent analysis of premium rate requests in eight states finds that marketplace premium increases average below 6 percent.[4] It is therefore too soon to evaluate the increase in premiums from 2015 to 2016.

Blue Shield insurers are monopolies or near monopolies and, as a result, their offerings are among the lowest premium plans in those areas. In areas where the Blues have many competitors, they sometimes priced very aggressively, while in other markets they did not. In still others, Blues insurers developed lower priced subsidiaries with limited provider networks which usually allowed them to be strong competitors.

- Previously Medicaid-only insurers, which can either be local insurers or large national chains, are new entrants to these commercial markets in the last two years. They are generally very price competitive and seem to be becoming increasingly so over time.
- Insurers sponsored by or affiliated with large provider systems have entered the nongroup insurance market in a number of areas, and are also very price competitive in many of the markets in which they operate.
- Co-ops, defined technically as member owned insurers (the owners of the co-op are insured by the co-op), are spreading to more markets and are generally very price competitive, although some face significant financial difficulties.

Other results are summarized in Table 1.

*Participation in the Selected Marketplace Rating Regions.* Blue Cross Blue Shield insurers had the highest rate of participation of any insurer type, offering coverage in each of the rating regions we studied in both 2014 and 2015 (first panel, table 1). National insurers' participation increased from 28 rating regions to 45 between 2014 and 2015. Co-op participation increased from 26 rating regions in 2014 to 32 in 2015. Regional insurers and Medicaid insurers increased their presence in 2015, but more modestly. Provider-sponsored insurers offered coverage in only one additional rating region in 2015.

*Marketplace Entrances and Exits.* The second panel of Table 1 shows 2015 entrances and exits from markets by type of insurer. These entrances and exits allow us to see to what extent insurers of a given type are finding the marketplaces more attractive over time and to what extent other insurers of a given type have quickly found the marketplaces unattractive for one reason or another. The number of entrances into the marketplaces are greatest for national insurers, with 66 entrances. United Healthcare alone accounts for 32 of these marketplace entrances in 2015; Assurant, not having participated in any of the rating regions we selected in 2014, accounts for 21 entrances (details shown in tables 2 through 7). Other types of insurers entered marketplaces in 2015 as well, but at noticeably lower rates. There were very few exits from these marketplaces in 2015 across all insurer types.

*Aggressive Premium Positioning.* The third panel of Table 1 provides a count of the number of instances in which an insurer of a given type was in the lowest or second-lowest premium position among insurers' lowest-priced silver plans. We refer to insurers in one of these two lowest-premium positions in a rating region as being aggressive in premium setting. As the table shows, Medicaid insurers and co-ops were becoming more aggressive in premium setting in the second year of the reforms, whereas the Blue Cross Blue Shield insurers and the regional insurers were losing ground.

*Improving, Worsening and Staying the Same in Pricing Position, 2014 compared to 2015.* As the last panel of Table 1 shows, Medicaid insurers and co-ops were most likely to improve the premium ranking of their lowest-premium silver plans in 2015. In contrast, Blue Cross Blue

## Table 1: Marketplace Participation and Pricing Position of Insurers by Type in 73 Rating Regions in 30 States

| | Insurer Type | | | | | |
|---|---|---|---|---|---|---|
| | National Insurers | Regional Insurers | Blue Cross Blue Shield Insurers | Previously Medicaid Only Insurers | Provider Sponsored Insurers | Co-Ops |
| Number of Rating Regions (out of 73 studied) in which Insurers of this Type Participated in Marketplaces, 2014 | 28 | 30 | 73 | 25 | 34 | 26 |
| Number of Rating Regions (out of 73 studied) in which Insurers of this Type Participated in Marketplaces, 2015 | 45 | 35 | 73 | 29 | 35 | 32 |
| Number of Marketplace Entrances by Insurers of this Type, 2015 | 66 | 12 | 3 | 11 | 4 | 7 |
| Number of Marketplace Exits by Insurers of this Type, 2015 | 1 | 1 | 0 | 0 | 1 | 2 |
| Among Each Insurer's Lowest Priced Silver Plan Offering in Each Rating Region, Number of Instances Where an Insurer of this Type was in the Lowest or Second Lowest Priced Positioning, 2014 | 22 | 24 | 57 | 13 | 14 | 9 |
| Among Each Insurer's Lowest Priced Silver Plan Offering in Each Rating Region, Number of Instances Where an Insurer of this Type was in the Lowest or Second Lowest Priced Positioning, 2015 | 28 | 14 | 36 | 28 | 15 | 22 |
| Among Insurers of this Type Participating in a Rating Region in Both 2014 and 2015, Number With an Improved Pricing Position in 2015 | 1 | 4 | 10 | 28 | 16 | 16 |
| Among Insurers of this Type Participating in a Rating Region in Both 2014 and 2015, Number With an Unchanged Pricing Position in 2015 | 14 | 14 | 25 | 6 | 11 | 7 |
| Among Insurers of this Type Participating in a Rating Region in Both 2014 and 2015, Number With a Worse Pricing Position in 2015 | 24 | 29 | 62 | 5 | 16 | 6 |

*Notes: The Entrant/Exit counts do not include the instances where a subsidary left or entered the market. All-Savers is a subsidary of United Healthcare. Group Hospitalization and Medical Services is a subsidary of Carefirst. Coventry and Aetna merged in 2013. HealthAmerica Pennsylvania is a subsidary of Coventry.*

Shield insurers, national insurers and regional insurers were most likely to see their lowest-premium silver options worsen in the rankings.

# DATA AND METHODS

We present premium and insurer data for selected rating regions in 30 states, with a particular focus on the largest states. We show the premium for the lowest-cost silver plan offered by each insurer for a 40-year-old nonsmoker, and all the analyses presented and the insurer pricing rankings are based only on these plans. Because the lowest-cost silver plan in each area offers the least expensive entry to the marketplace into the most popular tier of coverage, and because silver plans are those to which the financial assistance is pegged (and the only ones for which cost-sharing reductions are available), we focus our analysis on these. We study the lowest-priced silver option offered

by each insurer because these are their most competitive plans in this tier and best allow an analysis of competitive dynamics in the market. Focusing solely on the silver tier (70 percent actuarial value plans) allows us to control for the average cost-sharing requirements (combination of deductibles, co-payments, coinsurance, out-of-pocket maximums) faced by a typical population enrolled in these plans. Of course, premiums are not the only factor on which insurers compete. Others factors important to consumers include carrier reputation and provider networks. Unfortunately, enrollment data is not generally available by insurer or plan, but there is significant evidence that consumer choice of plan is strongly driven by premiums. In 2014, for example, 65 percent of those enrolling in silver-level coverage through the marketplaces chose one of the two lowest-premium plans.[5]

For each state, we examine the rating region containing the largest city and a rating region comprising predominantly rural counties (when possible) as defined by the University of Iowa's RUPRI Center for Rural Health Policy Analysis. In some states we also include a rating region containing a second large metropolitan area. We have selected these 30 states to provide a geographic representation of the country. For states operating their own information technology platform, premium information was collected from the respective state marketplace websites. For states using the federal information technology platform, premium information was obtained from healthcare.gov.

The data is presented primarily by insurer type and premiums, and we indicate how each insurer ranks compared with others to provide market context. For this paper we focus on insurer types to assess whether an insurer's type is related to its pricing strategy or gauge competitive success in the marketplaces. We group the participating insurers into six types: national commercial (Table 2), regional or local commercial (Table 3), Blue Cross Blue Shield (Table 4), Medicaid (Table 5), provider-sponsored (Table 6), and co-ops (Table 7). Each table provides the name of the insurers participating in the rating regions selected, the monthly premium for a 40-year-old nonsmoker in each insurer's lowest-priced silver plan offering in that region in 2014 and 2015, and the pricing position for that insurer's lowest-premium silver offering in that year. For example, a pricing position of "1 of 8" means that the insurer offered the lowest-premium silver plan in the rating area out of eight insurers participating in the marketplace in that rating region. The position "2 of 6" means that the lowest-premium silver plan offered by that insurer ranked second-lowest among the six insurers participating in the marketplace in that rating region.

We define Medicaid insurers as those that only offered public insurance (Medicaid with or without Medicare) plans before 2014 nongroup open enrollment. If they offered Medicaid plans in addition to individual, small-group or large-group plans, then the insurer is classified according to its other characteristics. The co-ops were established under the ACA, and all members are listed on the National Alliance of State Health Co-Ops web site. The provider-sponsored insurers are those that are directly affiliated with a provider system (generally a hospital system). Blue Cross Blue Shield insurers are those that are members of the Blue Cross Blue Shield Association. Finally, we include state specific tables in appendix A. These include the same data as the main tables but they are organized by state instead of insurer type.

# DETAILED FINDINGS BY INSURER TYPE

## National Insurers: Greatly Expanding Their Presence in the Marketplaces, but Yet to Price Aggressively

National insurers, such as United Healthcare, Aetna, Cigna, Assurant and Humana, participated in 28 of the 73 rating regions we studied in 2014 (Table 2). In 2015, they participated in 45. In some regions, multiple national insurers entered the market in the second year of the marketplaces. There were 68 entries into markets by these insurers and one exit,[6] so their presence in the marketplaces is clearly expanding.

In 22 cases, national insurers had the lowest- or second-lowest-cost silver plans in 2014, out of 47 national insurers that year in these regions. In 2015, 28 were in the lowest- or second-lowest-cost silver plan spots, out of 107 national insurers in these regions that year. Of those national insurers participating in a rating region in both years, their competitive pricing position was very unlikely to improve; that occurred in only one case. Their competitive pricing position worsened in 24 cases and stayed the same in 14. Thus, though national insurers' participation is growing, they are generally not being aggressive in their pricing; they seem content to compete on brand name and reputation for the time being. In the 24 cases where the competitive pricing

# Table 2: Lowest Cost Silver Premium Pricing for National Commercial Carriers in Selected States and Regions

| State | Rating Area | Carrier Name | 2014 Pricing Position | | 2015 Pricing Position | |
|---|---|---|---|---|---|---|
| Alabama | Rating Area 3: Birmingham | Humana Insurance Company | $255 | (1 of 2) | $262 | (1 of 3) |
| | | United Healthcare | N/A | | $264 | (2 of 3) |
| | Rating Area 13: Rural | United Healthcare | N/A | | $260 | (2 of 2) |
| Arizona | Rating Area 4: Phoenix | Humana Health Plan, Inc. | $218 | (3 of 8) | $265 | (9 of 11) |
| | | Aetna | $260 | (5 of 8) | $257 | (7 of 11) |
| | | Cigna Healthcare | $306 | (7 of 8) | $350 | (11 of 11) |
| | | United Healthcare | N/A | | $262 | (8 of 11) |
| | | Assurant Health | N/A | | $314 | (10 of 11) |
| | Rating Area 6: Tuscon | Humana Health Plan, Inc. | $198 | (2 of 8) | $238 | (8 of 10) |
| | | Aetna | $260 | (6 of 8) | $221 | (6 of 10) |
| | | Cigna Healthcare | $271 | (7 of 8) | $290 | (9 of 10) |
| | | United Healthcare | N/A | | $217 | (5 of 10) |
| | | Assurant Health | N/A | | $313 | (10 of 10) |
| Colorado | Rating Area 3: Denver | Humana | $250 | (2 of 10) | $242 | (2 of 8) |
| | | Cigna Healthcare | $318 | (7 of 10) | $339 | (8 of 8) |
| | | All-Savers | $381 | (9 of 10) | N/A | |
| | Rating Area 2: Colorado Springs | Humana | $242 | (1 of 7) | $233 | (2 of 7) |
| Connecticut | Rating Area 1: Bridgeport | United Healthcare | N/A | | $407 | (3 of 4) |
| | Rating Area 2: Hartford | United Healthcare | N/A | | $386 | (4 of 4) |
| Florida | Rating Area 43: Miami | Coventry Health Care of Florida, Inc. | $269 | (2 of 9) | $309 | (4 of 9) |
| | | Humana Medical Plan, Inc. | $274 | (3 of 9) | $301 | (3 of 9) |
| | | Aetna | $318 | (5 of 9) | N/A | |
| | | Cigna Healthcare | $351 | (8 of 9) | $419 | (8 of 9) |
| | | Assurant Health | N/A | | $397 | (7 of 9) |
| | Rating Area 15: Jacksonville | Coventry Health Care of Florida, Inc. | $227 | (1 of 4) | $271 | (1 of 4) |
| | | Aetna | $338 | (4 of 4) | N/A | |
| | | Assurant Health | N/A | | $333 | (4 of 4) |
| | | UnitedHealthcare | N/A | | $280 | (2 of 4) |
| | Rating Area 12: Rural | UnitedHealthcare | N/A | | $296 | (1 of 4) |
| | | Assurant Health | N/A | | $333 | (2 of 4) |
| Georgia | Rating Area 3: Atlanta | Humana Employers Health Plan of Georgia, Inc. | $229 | (1 of 4) | $257 | (3 of 9) |
| | | Coventry Health Care of Georgia, Inc. | N/A | | $248 | (1 of 9) |
| | | UnitedHealthcare | N/A | | $320 | (6 of 9) |
| | | Cigna Healthcare | N/A | | $326 | (8 of 9) |
| | | Assurant Health | N/A | | $363 | (9 of 9) |
| | Rating Area 10: Rural | Humana Employers Health Plan of Georgia, Inc. | $229 | (1 of 4) | $259 | (1 of 8) |
| | | Coventry Health Care of Georgia, Inc. | N/A | | $266 | (2 of 8) |
| | | UnitedHealthcare | N/A | | $340 | (7 of 8) |
| | | Assurant Health | N/A | | $390 | (8 of 8) |
| Illinois | Rating Area 1: Chicago | Humana Health Plan, Inc. | $262 | (2 of 7) | $288 | (5 of 7) |
| | | Coventry Health Care | $334 | (4 of 7) | $330 | (6 of 7) |
| | | Aetna | $383 | (5 of 7) | $458 | (7 of 7) |
| | | UnitedHealthcare | N/A | (7 of 7) | $279 | (4 of 7) |
| | Rating Area 13: Rural | Coventry Health Care | N/A | | $348 | (4 of 4) |
| Indiana | Rating Area 10: Indianapolis | UnitedHealthcare | N/A | | $386 | (5 of 6) |
| | | Assurant Health | N/A | | $525 | (6 of 6) |
| | Rating Area 3: Rural | UnitedHealthcare | N/A | | $339 | (4 of 5) |
| | | Assurant Health | N/A | | $487 | (5 of 5) |
| Louisiana | Rating Area 1: New Orleans | UnitedHealthcare | N/A | | $296 | (1 of 5) |
| | Rating Area 7: Rural | UnitedHealthcare | N/A | | $322 | (1 of 4) |

## Table 2: Lowest Cost Silver Premium Pricing for National Commercial Carriers in Selected States and Regions *continued*

| State | Rating Area | Carrier Name | 2014 Pricing Position | | 2015 Pricing Position | |
|---|---|---|---|---|---|---|
| Maryland | Rating Area 1: Baltimore | All-Savers | $339 | (5 of 5) | $315 | (6 of 7) |
| | | Cigna Healthcare | N/A | | $340 | (7 of 7) |
| | | United Healthcare of the Mid-Atlantic | N/A | | $253 | (4 of 7) |
| | Rating Area 3: DC Suburbs | All-Savers | $339 | (5 of 5) | $315 | (6 of 7) |
| | | Cigna Healthcare | N/A | | $345 | (7 of 7) |
| | | United Healthcare of the Mid-Atlantic | N/A | | $259 | (5 of 7) |
| | Rating Area 2: Rural | All-Savers | $339 | (4 of 4) | $315 | (4 of 5) |
| | | Cigna Healthcare | N/A | | $345 | (5 of 5) |
| Michigan | Rating Area 1: Detroit | Humana Medical Plan of Michigan, Inc. | $190 | (1 of 9) | $219 | (1 of 12) |
| | | UnitedHealthcare | N/A | | $230 | (2 of 12) |
| | | Assurant Health | N/A | | $334 | (11 of 12) |
| | Rating Area 7: Lansing | Assurant Health | N/A | | $364 | (7 of 7) |
| Missouri | Rating Area 6: St. Louis | Coventry Health Care | $239 | (1 of 2) | $252 | (1 of 4) |
| | | UnitedHealthcare | N/A | | $284 | (2 of 4) |
| | | Cigna Healthcare | N/A | | $291 | (4 of 4) |
| | Rating Area 3: Kansas City | Coventry Health and Life | $238 | (1 of 2) | $258 | (3 of 3) |
| | | Humana Insurance Company | N/A | | $252 | (2 of 3) |
| | Rating Area 10: Rural | Coventry Health Care | $395 | (2 of 2) | $430 | (3 of 3) |
| | | UnitedHealthcare | N/A | | $310 | (1 of 3) |
| New Hampshire | Entire State | Assurant Health | N/A | | $474 | (5 of 5) |
| New Jersey | Entire State | United Healthcare | N/A | | $391 | (5 of 5) |
| New York | Rating Area 4: New York City | United Healthcare | $642 | (10 of 10) | $545 | (12 of 12) |
| North Carolina | Rating Area 4: Charlotte | Coventry Health Care of the Carolinas, Inc. | $307 | (2 of 2) | $324 | (1 of 3) |
| | | UnitedHealthcare | N/A | | $340 | (3 of 3) |
| | Rating Area 9: Rural | Coventry Health Care of the Carolinas, Inc. | $344 | (2 of 2) | $338 | (2 of 3) |
| | | UnitedHealthcare | N/A | | $267 | (1 of 3) |
| Ohio | Rating Area 9: Columbus | Aetna | N/A | | $303 | (3 of 8) |
| | | UnitedHealthcare | N/A | | $366 | (7 of 8) |
| | | Assurant Health | N/A | | $435 | (8 of 8) |
| | Rating Area 4: Cincinnati | Humana Health Plan of Ohio, Inc. | $216 | (1 of 7) | $253 | (3 of 11) |
| | | Aetna | N/A | | $298 | (6 of 11) |
| | | UnitedHealthcare | N/A | | $326 | (9 of 11) |
| | | Assurant Health | N/A | | $478 | (11 of 11) |
| | Rating Area 2: Rural | Assurant Health | N/A | | $430 | (5 of 5) |
| Pennsylvania | Rating Area 8: Philadelphia | Aetna | $347 | (2 of 2) | $287 | (2 of 4) |
| | | UnitedHealthcare | N/A | | $267 | (1 of 4) |
| | | Assurant Health | N/A | | $410 | (4 of 4) |
| | Rating Area 4: Pittsburgh | HealthAmerica Pennsylvania, Inc. | $269 | (2 of 3) | N/A | |
| | | Coventry | N/A | | $269 | (4 of 5) |
| | | UnitedHealthcare | N/A | | $204 | (3 of 5) |
| | | Assurant Health | N/A | | $306 | (5 of 5) |
| | Rating Area 5: Rural | HealthAmerica Pennsylvania, Inc. | $261 | (3 of 4) | N/A | |
| | | UnitedHealthcare | N/A | | $209 | (2 of 6) |
| | | Coventry | N/A | | $256 | (5 of 6) |
| | | Assurant Health | N/A | | $303 | (6 of 6) |
| Rhode Island | Entire State | United Healthcare | N/A | | $288 | (3 of 3) |

## Table 2: Lowest Cost Silver Premium Pricing for National Commercial Carriers in Selected States and Regions *continued*

| State | Rating Area | Carrier Name | 2014 Pricing Position | | 2015 Pricing Position | |
|---|---|---|---|---|---|---|
| Texas | Rating Area 10: Houston | Humana Health Plan of Texas, Inc. | $249 | (2 of 6) | $294 | (5 of 8) |
| | | Cigna Healthcare | $289 | (3 of 6) | $339 | (7 of 8) |
| | | Aetna | $312 | (4 of 6) | $327 | (6 of 8) |
| | | UnitedHealthcare | N/A | | $264 | (3 of 8) |
| | | Assurant Health | N/A | | $432 | (8 of 8) |
| | Rating Area 8: Dallas | Cigna Healthcare | $300 | (2 of 4) | $364 | (6 of 7) |
| | | Aetna | $396 | (4 of 4) | $361 | (5 of 7) |
| | | UnitedHealthcare | N/A | | $290 | (3 of 7) |
| | | Assurant Health | N/A | | $475 | (7 of 7) |
| | Rating Area 19: San Antonio | Humana Health Plan of Texas, Inc. | $205 | (1 of 5) | $223 | (1 of 8) |
| | | Aetna | $268 | (3 of 5) | $273 | (7 of 8) |
| | | UnitedHealthcare | N/A | | $244 | (4 of 8) |
| | | Assurant Health | N/A | (4 of 4) | $307 | (8 of 8) |
| Virginia | Ratin Area: 7: Richmond | Coventry Health Care of Virginia, Inc. | $230 | (1 of 4) | $241 | (1 of 3) |
| | | Aetna Life Insurance Company | $317 | (3 of 4) | N/A | |
| Wisconsin | Rating Area 1: Milwaukee | UnitedHealthcare | N/A | | $355 | (4 of 6) |
| | Rating Area 10: Rural | UnitedHealthcare | N/A | | $364 | (5 of 5) |

Sources: Healthcare.gov for the Federally Facilitated Marketplaces, Federally Facilitated Marketplace – Partnership states, and Federally Supported State Based Marketplaces. State Based Marketplace data is from the respective State Based Marketplace websites

*Notes: Premium information displayed is for a 40 year old individual, non-smoker. The premium price shown is for the lowest cost silver offering for the given insurer. The number displayed in parentheses is the pricing position of the given insurer's lowest cost silver option in relation to the other insurers' lowest cost silver options in that market.*

position worsened in 2015, 11 had premium increases of more than 10 percent in the second year.

The following are some examples of national insurer experience in the first two years of the marketplaces:

- United Healthcare entered 32 of the markets studied in 2015, having been in only one in 2014. In well over half the cases, however, the insurer is pricing quite high or at least in the highest-cost half of insurers in those regions.
- Assurant entered 21 of these markets in 2015, having not been in any of them in 2014. Even more consistently than United Healthcare, however, Assurant has set premiums for its lowest-cost silver plan at or near the top of the spread.
- Quite consistently, Humana set premiums very competitively in the 2014 markets in which they participated, holding the lowest- or second-lowest-cost silver plan position in 11 of 14 rating regions. Their competitive pricing position slipped somewhat in 2015, but they remain significantly more price competitive than United Healthcare, Assurant, and Cigna tend to be. Coventry, which merged with Aetna in 2014, tends to be more price competitive in the markets where it participates.
- In the Phoenix and Tucson, Arizona, rating areas, Humana and Cigna both lost price competitive ground with significant premium increases in 2015 (20 percent to 22 percent for Humana and 7 percent to 14 percent for Cigna). Aetna lowered premiums slightly in Phoenix and more significantly in Tucson, but the insurer remains in the higher half of the lowest-cost silver plan premium distribution. United and Assurant both entered these markets in 2015, but neither was particularly price competitive.

### Regional Insurers: Participating More but Losing Price Competitive Ground in 2015

Regional insurers participated in 30 of the 73 marketplace regions we studied in 2014 and participated in 35 of them in 2015 (Table 3). There were 12 entries in 2015 by regional insurers into markets in which they had not participated in 2014. In only one case did a regional insurer that participated in the marketplace in 2014 leave it in 2015.

In 47 cases, regional insurers participated in the marketplaces studied in both years, but in 29 of those their competitive pricing position worsened in 2015. In most of these cases, the insurers had small (less than 5 percent) increases in their lowest-cost silver premiums, but in 14 cases the premium of their lowest-cost option increased

# Table 3: Lowest Cost Silver Premium Pricing for Regional Insurers in Selected States and Regions

| State | Rating Area | Carrier Name | 2014 Pricing Position | | 2015 Pricing Position | |
|---|---|---|---|---|---|---|
| Arizona | Rating Area 4: Phoenix | Health Net of Arizona, Inc. | $194 | (1 of 8) | $222 | (4 of 11) |
| | Rating Area 6: Tuscon | Health Net of Arizona, Inc. | $166 | (1 of 8) | $191 | (3 of 10) |
| Arkansas | Rating Area 1: Little Rock | QualChoice Health Insurance | $322 | (2 of 3) | $372 | (3 of 3) |
| | Rating Area 6: Rural | QualChoice | N/A | | $410 | (3 of 3) |
| California | Rating Area 15: Los Angeles 1 | Health Net | $222 | (1 of 6) | $230 | (1 of 7) |
| | | LA Care | $253 | (2 of 6) | $265 | (4 of 7) |
| | Rating Area 16: Los Angeles 2 | Health Net | $242 | (1 of 6) | $247 | (1 of 7) |
| | | LA Care | $265 | (3 of 6) | $278 | (4 of 7) |
| | Rating Area 4: San francisco | Chinese Community Health Plan | $328 | (1 of 5) | $356 | (1 of 5) |
| | | Health Net | $423 | (5 of 5) | $449 | (5 of 5) |
| Colorado | Rating Area 3: Denver | Rocky Mountain Health Plans | $309 | (6 of 10) | $336 | (7 of 8) |
| | | New Health Ventures (Access Health Colorado) | $454 | (10 of 10) | $274 | (4 of 8) |
| | Rating Area 5: Grand Junction | Rocky Mountain Health Plans | $285 | (1 of 4) | $286 | (1 of 4) |
| | | New Health Ventures (Access Health Colorado) | $503 | (4 of 4) | $396 | (4 of 4) |
| | Rating Area 2: Colorado Springs | Rocky Mountain Health Plans | $274 | (4 of 7) | $304 | (7 of 7) |
| | | New Health Ventures (Access Health Colorado) | $416 | (7 of 7) | $251 | (3 of 7) |
| Connecticut | Rating Area 1: Brideport | Connecticare | $383 | (1 of 3) | $395 | (2 of 4) |
| | Rating Area 2: Hartford | Connecticare | $316 | (1 of 3) | $321 | (1 of 4) |
| Louisiana | Rating Area 1: New Orleans | Vantage Health Plan, Inc. | $313 | (2 of 4) | $358 | (3 of 5) |
| | Rating Area 5: Baton Rouge | Vantage Health Plan, Inc. | $313 | (3 of 4) | $358 | (3 of 4) |
| | Rating Area 7: Rural | Vantage Health Plan, Inc. | $313 | (1 of 3) | $358 | (3 of 4) |
| Maine | Rating Area 1: Portland | Harvard Pilgrim Health Care | N/A | | $364 | (3 of 3) |
| | Rating Area 3: Rural | Harvard Pilgrim Health Care | N/A | | $404 | (3 of 3) |
| Michigan | Rating Area 1: Detroit | Total Health Care USA, Inc. | $224 | (2 of 9) | $243 | (4 of 12) |
| Minnesota | Rating Area 8: Minneapolis | HealthPartners | $166 | (2 of 5) | $181 | (1 of 5) |
| | Rating Area 2: Duluth | HealthPartners | $213 | (1 of 3) | $235 | (2 of 4) |
| New Hampshire | Entire State | Harvard Pilgrim | N/A | | $295 | (3 of 5) |
| New Jersey | Entire State | AmeriHealth New Jersey | $318 | (1 of 3) | $355 | (3 of 5) |
| | | Oscar | N/A | | $357 | (4 of 5) |
| New York | Rating Area 4: New York City | Oscar | $385 | (3 of 10) | $394 | (6 of 12) |
| | | Emblem | $385 | (4 of 10) | $407 | (8 of 12) |
| | | MVP Health | N/A | | $472 | (9 of 12) |
| | Rating Area 2: Buffalo | Univera | $430 | (4 of 5) | $474 | (6 of 6) |
| | | IHBC | $432 | (5 of 5) | $428 | (5 of 6) |
| | | MVP Health | N/A | | $365 | (3 of 6) |
| | Rating Area 7: Rural | MVP Health | $373 | (2 of 5) | $431 | (3 of 7) |
| | | Emblem | N/A | | $278 | (1 of 7) |
| Ohio | Rating Area 9: Columbus | MedMutual | $354 | (3 of 4) | $352 | (6 of 8) |
| | Rating Area 4: Cincinnati | HealthSpan | $274 | (4 of 7) | $268 | (4 of 11) |
| | | MedMutual | $359 | (6 of 7) | $353 | (10 of 11) |
| | Rating Area 2: Rural | HealthSpan | $281 | (1 of 3) | $270 | (1 of 5) |
| | | MedMutual | $345 | (3 of 3) | $357 | (3 of 5) |
| Oregon | Rating Area 1: Portland | Moda | $194 | (1 of 9) | $213 | (2 of 8) |
| | | Health Net | $215 | (2 of 9) | N/A | |
| | | PacificSource | $248 | (4 of 9) | $250 | (8 of 8) |
| | Rating Area 3: Salem | Moda | $201 | (1 of 9) | $221 | (1 of 8) |
| | | PacificSource | $248 | (3 of 9) | $253 | (7 of 8) |
| | | ATRIO | $278 | (8 of 9) | $233 | (2 of 8) |
| | Rating Area 6: Rural | Moda | $213 | (1 of 6) | $235 | (1 of 7) |
| | | PacificSource | $293 | (4 of 6) | $281 | (5 of 7) |

## Table 3: Lowest Cost Silver Premium Pricing for Regional Insurers in Selected States and Regions *continued*

| State | Rating Area | Carrier Name | 2014 Pricing Position | | 2015 Pricing Position | |
|---|---|---|---|---|---|---|
| Texas | Rating Area 19: San Antonio | Allegian Choice | N/A | | $271 | (6 of 8) |
| Washington | Rating Area 1: Seattle | Group Health | $281 | (2 of 9) | $281 | (4 of 9) |
| | | Community Health Plans | $335 | (7 of 9) | $343 | (9 of 9) |
| | | Moda | N/A | (9 of 9) | $284 | (5 of 9) |
| | Rating Area 4: Spokane | Group Health | $268 | (3 of 7) | $269 | (7 of 9) |
| | | Community Health Plans | $322 | (6 of 7) | $332 | (9 of 9) |
| | | Moda | N/A | | $284 | (8 of 9) |
| | Rating Area 5: Rural | Group Health | $282 | (2 of 5) | $282 | (3 of 8) |
| | | | $369 | (5 of 5) | $361 | (8 of 8) |
| | | Moda | N/A | | $284 | (4 of 8) |

Sources: Healthcare.gov for the Federally Facilitated Marketplaces, Federally Facilitated Marketplace - Partnership states, and Federally Supported State Based Marketplaces. State Based Marketplace data is from the respective State Based Marketplace websites.

*Notes: Premium information displayed is for a 40 year old individual, non-smoker. The premium price shown is for the lowest cost silver offering for the given insurer. The number displayed in parentheses is the pricing position of the given insurer's lowest cost silver option in relation to the other insurers' lowest cost silver options in that market.*

10 percent or more. Regional insurer pricing positions improved in four cases and stayed the same in 14. In three of the four cases where regional insurers' positioning improved in 2015, they had decreased their lowest-cost silver premium substantially.

In 2014, there were 24 instances where a regional insurer was in one of the top two price competitive positions in their rating region, but this was only true in 14 cases in 2015, as they seem to be struggling to remain competitive.

Some examples of regional insurers' marketplace experiences include:

- In New York City, the start-up Oscar Health and regional insurer EmblemHealth positioned themselves in the lower-priced half of this very competitive market (10 insurers) in 2014. However, their relatively modest premium increases (2 percent and 6 percent, respectively) left them in the higher-priced half of a market that now has an additional two insurers participating. And MVP Health Care, one of the new regional insurers there, entered in the ninth-most-competitive pricing position. Several other types of insurers lowered their premiums in New York City in 2015, including Fidelis Care, HealthFirst and Affinity (all previously Medicaid-only plans), North Shore-LIJ (a provider-sponsored plan), and United Healthcare (a national insurer).
- HealthPartners, a regional insurer, remained price competitive in both Minneapolis and Duluth in 2014 and 2015, although the insurer raised premiums in those areas by 9 percent and 10 percent, respectively.
- Moda Health entered the marketplaces in Oregon's Portland, Salem and rural markets very price competitively and has remained the lowest- or second-lowest-cost insurer in those markets despite 10 percent premium increases in 2015.
- However, Moda Health entered Washington markets in 2015 in the middle of insurers there, slightly in the more expensive half. This may have been because it set its 2015 lowest-cost silver premiums consistent with the lower-cost plans in those markets in 2014, misjudging the intensifying competition there in the second year of reform. Washington's other regional insurers, Group Health and Community Health plans, lost price competitive ground in the Washington rating areas studied, despite keeping premiums either constant (Group Health Cooperative) or increasing them modestly (Community Health Plans).

### Blue Cross Blue Shield: Most Widespread Marketplace Participation but Pursuing Very Different Pricing Strategies

Unlike any of the other insurer types, Blue Cross Blue Shield–affiliated insurers participated in each of the 73 rating regions we studied (Table 4). While their participation is widespread, Blue Cross Blue Shield insurers vary considerably across states. Anthem is a national for-profit carrier participating in many states. Others are local carriers that have changed from nonprofit to for-profit status, often to allow them to compete with for-profit commercial carriers.

# Table 4: Lowest Cost Silver Premium Pricing for Blue Cross Blue Shield Insurers in Selected States and Regions

| State | Rating Area | Carrier Name | 2014 Pricing Position | | 2015 Pricing Position | |
|---|---|---|---|---|---|---|
| Alabama | Rating Area 3: Birmingham | Blue Cross and Blue Shield of Alabama | $258 | (2 of 2) | $280 | (3 of 3) |
| | Rating Area 13: Rural | Blue Cross and Blue Shield of Alabama | $234 | (1 of 1) | $254 | (1 of 2) |
| Arizona | Rating Area 4: Phoenix | Blue Cross Blue Shield of Arizona, Inc. | $252 | (4 of 8) | $240 | (5 of 11) |
| | Rating Area 6: Tuscon | Blue Cross Blue Shield of Arizona, Inc. | $209 | (3 of 8) | $200 | (4 of 10) |
| Arkansas | Rating Area 1: Little Rock | Arkansas Blue Cross and Blue Shield | $294 | (1 of 3) | $294 | (1 of 3) |
| | Rating Area 6: Rural | Arkansas Blue Cross and Blue Shield | $294 | (1 of 1) | $295 | (2 of 3) |
| California | Rating Area 15: Los Angeles 1 | Blue Shield of California | $255 | (3 of 6) | $270 | (5 of 7) |
| | | Anthem Blue Cross | $257 | (4 of 6) | $257 | (2 of 7) |
| | | Anthem (MSP) | N/A | | $296 | (7 of 7) |
| | Rating Area 16: Los Angeles 2 | Anthem Blue Cross | $262 | (2 of 6) | $270 | (3 of 7) |
| | | Blue Shield of California | $290 | (5 of 6) | $308 | (6 of 7) |
| | | Anthem (MSP) | N/A | | $336 | (7 of 7) |
| | Rating Area 4: San Francisco | Anthem Blue Cross | $377 | (2 of 5) | $414 | (4 of 5) |
| | | Blue Shield of California | $378 | (3 of 5) | $401 | (3 of 5) |
| | Rating Area 1: Rural | Anthem Blue Cross | $312 | (1 of 3) | $325 | (1 of 3) |
| | | Blue Shield of California | $322 | (2 of 3) | $341 | (2 of 3) |
| Colorado | Rating Area 3: Denver | HMO Colorado (Anthem) | $320 | (8 of 10) | $316 | (5 of 8) |
| | Rating Area 5: Grand Junction | HMO Colorado (Anthem) | $359 | (2 of 4) | $359 | (3 of 4) |
| | Rating Area 2: Colorado Springs | HMO Colorado (Anthem) | $300 | (5 of 7) | $296 | (6 of 7) |
| Connecticut | Rating Area 1: Bridgeport | Anthem Blue Cross Blue Shield | $421 | (2 of 3) | $422 | (4 of 4) |
| | Rating Area 2: Hartford | Anthem Blue Cross Blue Shield | $328 | (2 of 3) | $334 | (3 of 4) |
| Florida | Rating Area 43: Miami | Florida Blue (BlueCross BlueShield FL) | $319 | (6 of 9) | $363 | (6 of 9) |
| | | Florida Blue HMO (a BlueCross BlueShield FL company) | $357 | (9 of 9) | $430 | (9 of 9) |
| | Rating Area 15: Jacksonville | Florida Blue (BlueCross BlueShield FL) | $256 | (2 of 4) | $291 | (3 of 4) |
| | | Florida Blue HMO (a BlueCross BlueShield FL company) | $282 | (3 of 4) | N/A | |
| | Rating Area 12: Rural | Florida Blue HMO (a BlueCross BlueShield FL company) | $269 | (1 of 2) | $333 | (2 of 4) |
| | | Florida Blue (BlueCross BlueShield FL) | $290 | (2 of 2) | $347 | (4 of 4) |
| Georgia | Rating Area 3: Atlanta | Blue Cross and Blue Shield of Georgia | $311 | (4 of 4) | $285 | (4 of 9) |
| | | Anthem Blue Cross and Blue Shield | N/A | | $319 | (5 of 9) |
| | Rating Area 10: Rural | Blue Cross and Blue Shield of Georgia | $295 | (2 of 4) | $269 | (3 of 8) |
| | | Anthem Blue Cross and Blue Shield | N/A | | $302 | (5 of 8) |
| Illinois | Rating Area 1: Chicago | Blue Cross Blue Shield of Illinois | $210 | (1 of 7) | $215 | (2 of 7) |
| | Rating Area 13: Rural | Blue Cross Blue Shield of Illinois | $278 | (1 of 3) | $298 | (3 of 4) |
| Indiana | Rating Area 10: Indianapolis | Anthem Blue Cross and Blue Shield | $339 | (1 of 2) | $351 | (3 of 6) |
| | Rating Area 3: Rural | Anthem Blue Cross and Blue Shield | $339 | (3 of 3) | $338 | (3 of 5) |
| Louisiana | Rating Area 1: New Orleans | HMO Louisiana | $295 | (1 of 4) | $297 | (2 of 5) |
| | | Blue Cross Blue Shield of Louisiana | $324 | (3 of 4) | $384 | (5 of 5) |
| | Rating Area 5: Baton Rouge | HMO Louisiana | $291 | (2 of 4) | $293 | (1 of 4) |
| | | Blue Cross Blue Shield of Louisiana | $330 | (4 of 4) | $392 | (4 of 4) |
| | Rating Area 7: Rural | Blue Cross Blue Shield of Louisiana | $320 | (2 of 3) | $381 | (4 of 4) |
| Maine | Rating Area 1: Portland | Anthem Blue Cross Blue Shield | $297 | (2 of 2) | $275 | (1 of 3) |
| | Rating Area 3: Rural | Anthem Blue Cross Blue Shield | $364 | (2 of 2) | $343 | (2 of 3) |
| Maryland | Rating Area 1: Baltimore | BlueChoice | $228 | (1 of 5) | $244 | (3 of 7) |
| | | Carefirst of Maryland | $240 | (2 of 5) | $274 | (5 of 7) |
| | Rating Area 3: DC Suburbs | BlueChoice | $213 | (1 of 5) | $227 | (2 of 7) |
| | | Carefirst of Maryland | $223 | (2 of 5) | $255 | (4 of 7) |
| | Rating Area 2: Rural | BlueChoice | $224 | (1 of 4) | $239 | (2 of 5) |
| | | Carefirst of Maryland | $235 | (2 of 4) | $268 | (3 of 5) |

# Table 4: Lowest Cost Silver Premium Pricing for Blue Cross Blue Shield Insurers in Selected States and Regions *continued*

| State | Rating Area | Carrier Name | 2014 Pricing Position | | 2015 Pricing Position | |
|---|---|---|---|---|---|---|
| Michigan | Rating Area 1: Detroit | Blue Care Network of Michigan | $242 | (3 of 9) | $234 | (3 of 12) |
| | | Blue Cross Blue Shield of Michigan | $311 | (6 of 9) | $301 | (9 of 12) |
| | Rating Area 7: Lansing | Blue Care Network of Michigan | $245 | (1 of 5) | $277 | (2 of 7) |
| | | Blue Cross Blue Shield of Michigan | $311 | (3 of 5) | $344 | (6 of 7) |
| | Rating Area 15: Rural | Blue Care Network of Michigan | $245 | (1 of 3) | $272 | (2 of 5) |
| | | Blue Cross Blue Shield of Michigan | $277 | (3 of 3) | $307 | (4 of 5) |
| Missouri | Rating Area 6: St. Louis | Anthem Blue Cross and Blue Shield | $263 | (2 of 2) | $289 | (3 of 4) |
| | Rating Area 3: Kansas City | Blue Cross and Blue Shield of Kansas City | $258 | (2 of 2) | $241 | (1 of 3) |
| | Rating Area 10: Rural | Anthem Blue Cross and Blue Shield | $346 | (1 of 2) | $381 | (2 of 3) |
| Minnesota | Rating Area 8: Minneapolis | Blue Cross Blue Shield Minneosta | $201 | (3 of 5) | $201 | (3 of 5) |
| | Rating Area 2: Duluth | Blue Cross Blue Shield Minneosta | $236 | (3 of 3) | $271 | (4 of 4) |
| New Hampshire | Entire State | Anthem Blue Cross and Blue Shield | $288 | (1 of 1) | $284 | (2 of 5) |
| New Jersey | Entire State | Horizon Blue Cross Blue Shield of New Jersey | $356 | (2 of 3) | $316 | (2 of 5) |
| New Mexico | Rating Area 1: Albuquerque | Blue Cross Blue Shield of New Mexico | $189 | (1 of 4) | $167 | (1 of 5) |
| | Rating Area 5: Rural | Blue Cross Blue Shield of New Mexico | $261 | (1 of 4) | $238 | (1 of 4) |
| New York | Rating Area 4: New York City | Empire Blue Cross Blue Shield | $418 | (6 of 10) | $448 | (10 of 12) |
| | Rating Area 2: Buffalo | BlueCross Blueshield of Western New York | $372 | (3 of 5) | $342 | (3 of 6) |
| | Rating Area 7: Rural | Excellus | $443 | (3 of 5) | $488 | (4 of 7) |
| | | Blueshield of Northeastern NY | $505 | (5 of 5) | $568 | (7 of 7) |
| North Carolina | Rating Area 4: Charlotte | Blue Cross and Blue Shield of NC | $301 | (1 of 2) | $328 | (2 of 3) |
| | Rating Area 9: Rural | Blue Cross and Blue Shield of NC | $319 | (1 of 2) | $362 | (3 of 3) |
| Ohio | Rating Area 9: Columbus | Anthem Blue Cross and Blue Shield | $317 | (2 of 4) | $342 | (5 of 8) |
| | Rating Area 4: Cincinnati | Anthem Blue Cross and Blue Shield | $294 | (5 of 7) | $319 | (8 of 11) |
| | Rating Area 2: Rural | Anthem Blue Cross and Blue Shield | $343 | (2 of 3) | $372 | (4 of 5) |
| Oregon | Rating Area 1: Portland | Lifewise | $248 | (4 of 9) | $244 | (6 of 8) |
| | | Bridgespan | $278 | (9 of 9) | $238 | (5 of 8) |
| | Rating Area 3: Salem | Lifewise | $254 | (4 of 9) | $250 | (6 of 8) |
| | | Bridgespan | $296 | (9 of 9) | $266 | (8 of 8) |
| | Rating Area 6: Rural | Bridgespan | $338 | (6 of 6) | $300 | (7 of 7) |
| | | Lifewise | $254 | (3 of 6) | $250 | (3 of 7) |
| Pennsylvania | Rating Area 8: Philadelphia | Independence Blue Cross | $256 | (1 of 2) | $294 | (3 of 4) |
| | Rating Area 4: Pittsburgh | Highmark Inc. | $163 | (1 of 3) | $179 | (2 of 5) |
| | Rating Area 5: Rural | Highmark Inc. | $181 | (1 of 4) | $206 | (1 of 6) |
| Rhode Island | Entire State | Blue Cross Blue Shield of Rhode Island | $274 | (1 of 2) | $286 | (2 of 3) |
| Texas | Rating Area 10: Houston | Blue Cross Blue Shield of Texas | $238 | (1 of 6) | $250 | (2 of 8) |
| | Rating Area 8: Dallas | Blue Cross Blue Shield of Texas | $264 | (1 of 4) | $279 | (1 of 7) |
| | Rating Area 19: San Antonio | Blue Cross Blue Shield of Texas | $239 | (2 of 5) | $254 | (5 of 8) |
| Virginia | Rating Area 7: Richmond | HealthKeepers, Inc. | $253 | (2 of 4) | $264 | (2 of 3) |
| | Rating Area 9: Virginia Beach | HealthKeepers, Inc. | $278 | (2 of 2) | $287 | (2 of 2) |
| | Rating Area 12: Rural | HealthKeepers, Inc. | $277 | (2 of 3) | $284 | (2 of 3) |
| | Rating Area 10: Northern Virginia | CareFirst BlueChoice, Inc. | $272 | (2 of 5) | $323 | (4 of 5) |
| | | HealthKeepers, Inc. | $289 | (4 of 5) | $292 | (3 of 5) |
| | | Group Hospitalization and Medical Services Inc. | $301 | (5 of 5) | N/A | |
| | | CareFirst BlueCross BlueShield | N/A | | $347 | (5 of 5) |

## Table 4: Lowest Cost Silver Premium Pricing for Blue Cross Blue Shield Insurers in Selected States and Regions *continued*

| State | Rating Area | Carrier Name | 2014 Pricing Position | | 2015 Pricing Position | |
|---|---|---|---|---|---|---|
| Washington | Rating Area 1: Seattle | Premera | $283 | (3 of 9) | $291 | (7 of 9) |
| | | Bridgespan | $300 | (5 of 9) | $254 | (2 of 9) |
| | | Lifewise | $283 | (3 of 9) | $291 | (7 of 9) |
| | | Premera (MSP) | N/A | (8 of 9) | $290 | (6 of 9) |
| | Rating Area 4: Spokane | Premera | $260 | (2 of 7) | $267 | (5 of 9) |
| | | Bridgespan | $295 | (5 of 7) | $255 | (2 of 9) |
| | | Lifewise | $260 | (3 of 7) | $267 | (5 of 9) |
| | | Premera (MSP) | N/A | | $267 | (4 of 9) |
| | Rating Area 5: Rural | Premera | $283 | (3 of 5) | $291 | (6 of 8) |
| | | Bridgespan | N/A | | $263 | (2 of 8) |
| | | Lifewise | $283 | (3 of 5) | $291 | (6 of 8) |
| | | Premera (MSP) | N/A | | $290 | (5 of 8) |
| Wisconsin | Rating Area 1: Milwaukee | Anthem Blue Cross and Blue Shield | $302 | (1 of 4) | $348 | (3 of 6) |
| | Rating Area 10: Rural | Anthem Blue Cross and Blue Shield | $312 | (3 of 3) | $359 | (4 of 5) |
| West Virginia | Rating Area 2: Charleston | Highmark Inc. | $288 | (1 of 1) | $314 | (1 of 1) |
| | Rating Area 9: Rural | Highmark Inc. | $262 | (1 of 1) | $286 | (1 of 1) |

Sources: Healthcare.gov for the Federally Facilitated Marketplaces, Federally Facilitated Marketplace - Partnership states, and Federally Supported State Based Marketplaces. State Based Marketplace data is from the respective State Based Marketplace websites

*Notes: Premium information displayed is for a 40 year old individual, non-smoker. The premium price shown is for the lowest cost silver offering for the given insurer. The number displayed in parentheses is the pricing position of the given insurer's lowest cost silver option in relation to the other insurers' lowest cost silver options in that market.*

Others have retained their nonprofit status but are often local monopolies. Some of the Blue Cross Blue Shield insurers have subsidiaries participating in the same regions with them under different names. Sometimes a separately named offering was a multistate plan.[7] In a small number of cases, including the Seattle rating region, a Blue Shield insurer competes with a Blue Cross one because the two entities never merged as they did in most of the U.S.[8]

The pricing strategies of the Blues insurers vary considerably across the rating regions. Though some entered 2014 with competitive premiums and remain competitive in 2015, much more often than not, the competitive pricing position of theBlues have worsened in 2015. In 2014, in 57 instances, Blues insurers offered one of the two lowest-premium plans among all insurers' lowest-premium silver plans, but in 2015 this was true in only 36 cases. By 2015, their lowest-priced silver plans often fell in the middle or near the high end for all insurers in a rating region. In some cases, a Blues insurer is the primary, if not the only, insurer in a market, but this is significantly less likely to be the case in 2015 than in 2014. For example, Arkansas Blue Cross and Blue Shield was the only marketplace insurer in the selected rural rating region in 2014, but two additional insurers entered that region for 2015. Likewise, Blue Cross Blue Shield was the only insurer participating in New Hampshire in 2014, but there were four new entrants in 2015.

Blue Cross Blue Shield insurers fall into four different types of competitive positions, each discussed in turn below: rating regions with very little competition, where the Blues dominate the region (10 regions); rating regions where the Blues face many competing insurers and the Blues price quite low (30 regions); rating regions where there are many competing insurers yet the Blues do not price competitively (15 regions); and rating regions where the Blues take a split market approach, pricing their traditional plans in the middle or at the higher end of the market but introducing a narrow network, lower-cost subsidiary in an effort to capture the more cost-conscious segment of consumers (18 regions).

*Markets without many competitors.* In markets in which there is not a lot of insurer competition, Blue Cross Blue Shield insurers tend to have their lowest-priced silver plan at the low end of the premium range in that rating region. Examples of this type of market include:

- Arkansas: Little Rock had three insurers in both 2014 and 2015. The rural rating region we studied had only one Blues insurer in 2014, but two additional insurers entered the marketplace in the region in 2015. Arkansas Blue Cross and Blue Shield kept the premium for its

lowest-cost silver plan fixed in 2015 in Little Rock, securing its place as the lowest-cost insurer in that area. Though the insurer took essentially the same zero-growth pricing strategy in the rural area, one of the two new insurers in that market, Ambetter (a previously Medicaid-only insurer), underpriced the Blues slightly in 2015. The other new entrant set its premiums much higher.

- Maine and North Carolina: Portland and the selected rural rating area in Maine had only two insurers in 2014 and three in 2015. The same was true in North Carolina's Charlotte and in the selected rural rating area in the state. Though Anthem Blue Cross Blue Shield lowered its premiums in 2014 in Maine, keeping its pricing position, Blue Cross and Blue Shield of North Carolina increased its 2015 lowest-priced silver premium, causing it to lose its pricing edge.

- West Virginia: Highmark Blue Cross was the only insurer participating in the state's marketplace in both 2014 and 2015, and its lowest-cost silver premium increased 9 percent in 2015.

- Alabama: Blue Cross and Blue Shield of Alabama has been the dominant insurer in the Alabama market for many years. In the marketplace, Birmingham had only two insurers in 2014 and three in 2015, and the rural rating area we selected had one Blues insurer in 2014 with a second insurer entering in 2015. Blue Cross and Blue Shield of Alabama faced competition in Birmingham from Humana in both years, with United Healthcare entering the market in 2015. Both of Blue Cross and Blue Shield of Alabama's competitors offered lower premium options than it did in 2015, though the premium differences across insurers were quite small. Blue Cross and Blue Shield of Alabama kept its lowest-priced plan slightly below that of United Healthcare in the rural area in 2015.

- New Hampshire: Anthem Blue Cross Blue Shield was the only plan in 2014. In 2015 there were four new entrants with one, a co-op, becoming the lowest-priced plan; Anthem became the second-lowest priced plan.

*Markets with significant numbers of competitors and aggressive pricing by the Blues.* In some markets, many insurers compete with the Blues. However, the positioning of the Blues' lowest-cost silver plan offerings varies considerably across the rating regions. The following are examples of rating regions where the Blues have at least some very price competitive plans:

- Chicago has six insurers competing with Blue Cross Blue Shield of Illinois in 2015. The Blues' lowest-cost silver plan premium was the lowest-priced option in 2014, and only one insurer offered a lower-cost silver plan in 2015.

- In Los Angeles, Anthem Blue Cross was among the lowest cost plans in 2015, but Blue Shield of California and the Anthem multistate plan were not.

- In Albuquerque and one rural area in New Mexico, Blue Cross Blue Shield of New Mexico offered the lowest-priced silver option among four and five insurers in 2014 and 2015, respectively.

- In both Houston and Dallas, Blue Cross Blue Shield of Texas offered either the lowest-priced silver option or very close to it in both years, among four to eight competing insurers, depending upon the year and the rating region.

- In each of the three markets we studied in Pennsylvania, Blue Cross plans were the lowest-priced or near to the lowest-priced plans.

*Markets with significant numbers of competitors where the Blues do not price aggressively.* Though the Blues price aggressively in many competitive markets as we show above, this is not always the case:

- Anthem Blue Cross and Blue Shield had six competitors in Cincinnati in 2014 and 10 competitors in 2015. The competitive price positioning of its lowest-cost silver option fell from 5th place to 8th place across the first two years of reform.

- In Miami, Florida Blue and Florida Blue HMO compete in the marketplace alongside seven other insurers. Of each of these insurers' lowest-priced silver plan options, Florida Blue HMO's was the most expensive in both years and Florida Blue's was the sixth-most expensive among the nine.

- In New York City, Empire Blue Cross Blue Shield had nine competitors in 2014 and 11 competitors in 2015 in the nongroup marketplace. In 2014, their lowest-cost silver plan premium was in the middle of the pack, though it was at the high end in 2015. Competition there is quite tough, dominated by multiple insurers that previously offered Medicaid-only plans and a co-op.

- The competition in Atlanta increased significantly in 2015, with the number of insurers participating in the marketplace in that region going up from four to nine.

In the rural rating region we included in Georgia, the number of insurers increased from four to eight. In both those rating regions, Anthem Blue Cross and Blue Shield entered the marketplace for the first time in 2015, setting its lowest-cost silver premium offering in both cases in the more expensive half of insurers. Meanwhile, Blue Cross and Blue Shield of Georgia, participating in both years, lowered the premium for their lowest-cost silver option in the second year, allowing it to be somewhat more competitive in these markets.

*Markets where the Blues introduced new subsidiaries with narrower provider networks.* In yet another set of markets, the Blues have created a separate subsidiary, typically one with a more limited network. Sometimes these subsidiaries offer plans alongside the more expensive traditional Blues offerings in the marketplaces; in other areas the less expensive subsidiaries are the only Blues plans available. Examples include Louisiana, Maryland, Michigan, Virginia, and Washington:

- Louisiana's Blue Cross Blue Shield HMO's lowest-cost silver plan was the least expensive or second-least expensive offering in New Orleans and Baton Rouge in both 2014 and 2015. The lowest-cost silver option offered by Blue Cross Blue Shield of Louisiana, however, tended to be the most expensive across the four to five insurers participating in the marketplace in these cities.

- BlueChoice, a limited network subsidiary offered by CareFirst in Maryland, offered the lowest-cost silver plan in 2014 in Baltimore; the Washington, D.C. suburbs; and in the rural area we included. In 2015, BlueChoice remained very competitive, particularly in the Washington, D.C., suburbs and the rural area, where its lowest-cost option had almost exactly the same premium as that of the most price competitive insurer. CareFirst of Maryland, the traditional Blue Cross offeror, was in the more expensive half of silver options by 2015 in all three rating areas of the state we studied.

- The Blue Care Network ranked third-lowest among the Detroit insurers' lowest-cost silver premiums in both 2014 and 2015. It ranked lowest in 2014 and second-lowest in 2015 in Lansing and the rural area we studied. The traditional Blue Cross Blue Shield offeror in these regions had significantly higher premiums.

- The HealthKeepers subsidiary of Anthem Blue Cross was very price competitive in the Virginia rating areas we studied. Though HealthKeepers did not offer the least expensive silver plan in these rating areas in 2014 or 2015, its lowest-cost option was close to the premium leader in these regions.

- Bridgespan, a subsidiary of Regence Blue Shield, was among the lowest-priced plans in Washington markets in 2015, but not in Oregon.

## Previously Medicaid-Only Insurers: A Growing Marketplace Presence That Is Getting Increasingly Price Competitive

The development of the ACA's insurance marketplaces created an attractive avenue for some private insurers that had previously only served Medicaid beneficiaries to enter the nongroup insurance market. At least one of these Medicaid insurers participated in 29 of the 73 rating regions we studied in 2015, with multiple Medicaid insurers participating in 15 of those rating regions in 2015 (Table 5). The presence of these types of insurers in these marketplaces grew almost 25 percent between 2014 and 2015. These insurers had historically negotiated provider payment rates that were lower than typical private sector rates to stay within the capitation rates set by each state's Medicaid program. Though most of them likely had to increase their payment rates with the providers with whom they had previous relationships to expand into the private insurance market, in some areas the relationships seem to have allowed them to continue at lower payment rates than is typical for private insurers.

Medicaid insurers are typically local entities, often developed by safety-net providers that serve significant numbers of Medicaid beneficiaries. There are also national firms, however, such as Centene and Molina Healthcare, that offer Medicaid plans in several states and participate in marketplaces in a subset of those states. Many of these insurers decided to participate in the ACA's marketplaces to maintain their clients as their life circumstances fluctuate and they move from Medicaid to tax credit eligibility and vice versa. Most eventually decided that they would compete for the full range of marketplace enrollees, not only those with low incomes.

Medicaid insurers have competitive premiums, holding one or both of the two lowest-premium silver plan positions in 23 of the 29 rating regions in which they participated in 2015. This strong showing is an improvement in their competitive pricing positioning between 2014 and 2015. In 2015, the share of Medicaid insurers in these regions offering the lowest-premium silver plan more than doubled, and the share in the second-most price competitive position almost doubled, making Medicaid insurers among the top two most price competitive insurers in more than half of the

# Table 5: Lowest Cost Silver Premium Pricing for Previously Medicaid only Insurers in Selected States and Regions

| State | Rating Area | Carrier Name | 2014 Pricing Position | | 2015 Pricing Position | |
|---|---|---|---|---|---|---|
| Arizona | Rating Area 4: Phoenix | Meritus Health Partners | $214 | (2 of 8) | $166 | (1 of 11) |
| | | Health Choice Insurance Co. | $283 | (6 of 8) | $195 | (2 of 11) |
| | | Phoenix Health Plan | N/A | | $252 | (6 of 11) |
| | Rating Area 6: Tuscon | Meritus Health Partners | $234 | (4 of 8) | $170 | (1 of 10) |
| | | Health Choice Insurance Co. | $247 | (5 of 8) | $232 | (7 of 10) |
| Arkansas | Rating Area 1: Little Rock | Ambetter of Arkansas | $328 | (3 of 3) | $332 | (2 of 3) |
| | Rating Area 6: Rural | Ambetter of Arkansas | N/A | | $291 | (1 of 3) |
| California | Rating Area 15: Los Angeles 1 | Molina | $262 | (5 of 6) | $259 | (3 of 7) |
| | Rating Area 16: Los Angeles 2 | Molina | $262 | (3 of 6) | $259 | (2 of 7) |
| Florida | Rating Area 43: Miami | Preferred Medical Plan, Inc. | $247 | (1 of 9) | $350 | (5 of 9) |
| | | Molina Healthcare of Florida, Inc | $309 | (4 of 9) | $274 | (2 of 9) |
| | | Ambetter from Sunshine Health | $345 | (7 of 9) | $274 | (1 of 9) |
| Georgia | Rating Area 3: Atlanta | Ambetter from Peach State Health Plan | $301 | (3 of 4) | $255 | (2 of 9) |
| Illinois | Rating Area 1: Chicago | IlliniCare Health | N/A | | $221 | (3 of 7) |
| Indiana | Rating Area 10: Indianapolis | Ambetter from MHS | N/A | | $329 | (2 of 6) |
| | | CareSource Just4Me | N/A | | $317 | (1 of 6) |
| | Rating area 3: Rural | Ambetter from MHS | $334 | (2 of 3) | $285 | (1 of 5) |
| Michigan | Rating Area 1: Detroit | Molina Healthcare of Michigan, Inc. | $327 | (8 of 9) | $252 | (5 of 12) |
| | | Harbor Choice | N/A | | $301 | (8 of 12) |
| Minnesota | Rating Area 8: Minneapolis | Ucare | $203 | (4 of 5) | $183 | (2 of 5) |
| | | Medica | $211 | (5 of 5) | $222 | (5 of 5) |
| | Rating Area 2: Duluth | Ucare | $233 | (2 of 3) | $206 | (1 of 4) |
| | | Medica | N/A | | $263 | (3 of 4) |
| New Mexico | Rating Area 1: Albuquerque | Molina Health Care of New Mexico, Inc. | $212 | (2 of 4) | $186 | (3 of 5) |
| | | CHRISTUS Health Plan | N/A | | $303 | (5 of 5) |
| | Rating Area 5: Rural | Molina Health Care of New Mexico, Inc. | $289 | (4 of 4) | $259 | (3 of 4) |
| New York | Rating Area 4: New York City | Metro Plus | $359 | (1 of 10) | $383 | (3 of 12) |
| | | Fidelis | $390 | (5 of 10) | $384 | (4 of 12) |
| | | HealthFirst | $440 | (8 of 10) | $387 | (5 of 12) |
| | | Affinity | $440 | (9 of 10) | $372 | (1 of 12) |
| | | Wellcare | N/A | | $417 | (11 of 12) |
| | Rating Area 2: Buffalo | Fidelis | $338 | (2 of 5) | $337 | (2 of 6) |
| | Rating Area 7: Rural | Fidelis | $337 | (1 of 5) | $356 | (2 of 7) |
| Ohio | Rating Area 9: Columbus | CareSource | $238 | (1 of 4) | $244 | (1 of 8) |
| | | MOLINA HEALTHCARE OF OHIO | $418 | (4 of 4) | $281 | (2 of 8) |
| | Rating Area 4 Cincinnati | CareSource | $238 | (2 of 7) | $232 | (1 of 11) |
| | | Ambetter from Buckeye Community Health Plan | $262 | (3 of 7) | $236 | (2 of 11) |
| | | MOLINA HEALTHCARE OF OHIO | $431 | (7 of 7) | $281 | (5 of 11) |
| Texas | Rating Area 10: Houston | Molina Marketplace | $313 | (5 of 6) | $268 | (4 of 8) |
| | | Community Health Choice | $343 | (6 of 6) | $248 | (1 of 8) |
| | Rating Area 8: Dallas | Molina Marketplace | $324 | (3 of 4) | $280 | (2 of 7) |
| | Rating Area 19: San Antonio | Ambetter from Superior Health Plan | $281 | (4 of 5) | $233 | (2 of 8) |
| Washington | Rating Area 1: Seattle | Coordinated Care | $245 | (1 of 9) | $235 | (1 of 9) |
| | | Molina | $311 | (6 of 9) | $277 | (3 of 9) |
| | Rating Area 4: Spokane | Coordinated Care | $235 | (1 of 7) | $219 | (1 of 9) |
| | | Molina | $357 | (7 of 7) | $265 | (3 of 9) |
| | Rating Area 5: Rural | Coordinated Care | $267 | (1 of 5) | $251 | (1 of 8) |
| Wisconsin | Rating Area 1: Milwaukee | Molina Healthcare of Wisconsin, Inc. | $341 | (4 of 4) | $301 | (1 of 6) |
| | | Ambetter from Managed Health Services | N/A | | $392 | (6 of 6) |
| | Rating Area 10: Rural | Molina Healthcare of Wisconsin, Inc. | N/A | | $328 | (3 of 5) |

Sources: Healthcare.gov for the Federally Facilitated Marketplaces, Federally Facilitated Marketplace – Partnership states, and Federally Supported State Based Marketplaces. State Based Marketplace data is from the respective State Based Marketplace websites.

*Notes: Premium information displayed is for a 40 year old individual, non-smoker. The premium price shown is for the lowest cost silver offering for the given insurer. The number displayed in parentheses is the pricing position of the given insurer's lowest cost silver option in relation to the other insurers' lowest cost silver options in that market.*

rating regions in which they operated. For those instances where a Medicaid insurer participated in a particular rating region in both years, the average reduction in the insurers' lowest-cost silver plan premium between 2014 and 2015 was 10 percent. These plans were much more likely to improve their competitive price positioning in 2015 than they were to worsen their position or stay the same.

Some examples of national Medicaid insurers' experiences in the marketplaces include the following:

- Centene, which markets Medicaid plans under the names Ambetter and Coordinated Care, has been highly successful in many markets, particularly in 2015. Ambetter's lowest-cost silver option was the second-lowest-priced plan in Little Rock and became the lowest-cost plan in rural Arkansas when it entered that market in 2015. Ambetter offered the lowest-cost plan in Miami in 2015 among eight other insurers, including two other Medicaid insurers. Its lowest–premium silver plan was the second lowest among eight other insurers in Atlanta. Ambetter was also highly competitive in rural Indiana, Cincinnati and the San Antonio market in Texas. Coordinated Care offered the lowest-premium silver plan in Washington state in each of the markets examined.
- Molina Healthcare's lowest-cost silver premiums were among the most price competitive offerings in Los Angeles, Columbus, Dallas, Houston, and Milwaukee in 2015. They were not as price competitive in Detroit or Cincinnati. In each of the studied markets in which they participated, however, their competitive position improved in 2015.

Some local Medicaid insurers also offered very price competitive plans:

- Meritus Health Partners in Arizona offered the lowest-cost silver plan in the Phoenix and Tucson markets in 2015.
- The CareSource plan was the lowest-cost silver plan in Indianapolis and in both the Columbus and Cincinnati markets in 2015.
- Ucare offered the lowest-cost silver plan in Duluth and was the second-lowest-cost insurer in Minneapolis in 2015.
- Local Medicaid plans were particularly successful in New York City, where five Medicaid insurers competed in a field of 12 marketplace insurers by 2015. MetroPlus offered the lowest-cost silver plan in 2014 and was ranked third among the 12 participating insurers in 2015. Two other local Medicaid insurers, Healthfirst and Affinity Health Plan, were among the highest priced New York City marketplace insurers in 2014 but became far more competitive in 2015. Fidelis Care, the only Medicaid insurer in New York that operates statewide, was among the lowest-cost insurers in Buffalo and rural New York and ranked fourth-lowest in New York City.

There are some Medicaid plans, such as Phoenix Health Plan in Phoenix, Arizona; Health Choice in Tucson, Arizona; Harbor Choice in Detroit, Michigan; WellCare in New York City; and Christus in Albuquerque, New Mexico, where premiums are high relative to the competition in those markets, but these cases are exceptions to the trend.

## Provider-Sponsored Insurers: A Modest Marketplace Presence That Has an Inconsistent Competitive Footing

Provider-sponsored insurers can differ significantly from each other in structure, but they are usually started by hospital and/or physician systems that develop a relationship with an already-established insurer. The most prominent of these is Kaiser Permanente, in which the insurer and the provider system or network are separate but have an exclusive relationship with one another. Kaiser is a prominent insurer in California, Oregon, Denver, Colorado, Atlanta, Georgia and the Washington, D.C., area (Table 6). But there are many others, often local. The Innovation Health plan was created by the INOVA Health System to compete with Carefirst and Kaiser Permanente in the Northern Virginia market. Optima Health is tied to the Sentara Healthcare system in the Norfolk area and elsewhere in Virginia. The Neighborhood Health Plan in Rhode Island is owned by Partners HealthCare, but at this point it does not have an exclusive arrangement with Partners providers.[9] The Geisinger Health Plan started as a provider-sponsored plan in central and northern Pennsylvania. The Providence Health System in Portland, Oregon created the Providence Plan. The North Shore-LIJ plan in New York was established by the North Shore-LIJ Health System.

Provider-sponsored insurers participated in 34 of the 73 rating regions studied in 2014 and 35 in 2015, slightly increasing their marketplace presence in these regions in 2015. Their competitive positioning has been mixed. For those participating in both years in a region, equal numbers experienced an increase or decrease in the premium ranking of their lowest-cost silver plans.

Some examples of marketplace experience among provider-sponsored insurers include:

# Table 6: Lowest Cost Silver Premium Pricing for Provider Sponsored Insurers in Selected States and Regions

| State | Rating Area | Carrier Name | 2014 Pricing Position | | 2015 Pricing Position | |
|---|---|---|---|---|---|---|
| Arizona | Rating Area 4: Phoenix | Uni. of Arizona Health Plans – University Healthcare Marketplace | $325 | (8 of 8) | $202 | (3 of 11) |
| | Rating Area 6: Tuscon | University of Arizona Health Plans – University Healthcare Marketplace | $290 | (8 of 8) | $189 | (2 of 10) |
| California | Rating Area 15: Los Angeles 1 | Kaiser Permanente | $297 | (6 of 6) | $287 | (6 of 7) |
| | Rating Area 16: Los Angeles 2 | Kaiser Permanente | $328 | (6 of 6) | $300 | (5 of 7) |
| | Rating Area 4: San Francisco | Kaiser Permanente | $387 | (3 of 5) | $393 | (2 of 5) |
| | Rating Area 1: Rural | Kaiser Permanente | $350 | (3 of 3) | $356 | (3 of 3) |
| Colorado | Rating Area 3: Denver | Kaiser Permanente | $245 | (1 of 10) | $272 | (3 of 10) |
| | | Denver Health Medical Plan | $275 | (4 of 10) | $318 | (6 of 10) |
| | Rating Area 2: Colorado Springs | Kaiser Permanente | $270 | (3 of 7) | $257 | (4 of 7) |
| Georgia | Rating Area 3: Atlanta | Kaiser Permanente | $297 | (2 of 4) | $323 | (7 of 9) |
| | Rating Area 10: Rural | Kaiser Permanente | $297 | (3 of 4) | $323 | (6 of 8) |
| | | Alliant Health Plans | $319 | (4 of 4) | $295 | (4 of 8) |
| Illinois | Rating Area 13: Rural | Health Alliance Medical Plans, Inc. | $301 | (2 of 3) | $293 | (2 of 4) |
| Indiana | Rating Area 10: Indianapolis | MDwise Marketplace | $356 | (2 of 2) | $365 | (4 of 6) |
| Maryland | Rating Area 1: Baltimore | Kaiser Permanente | $270 | (4 of 5) | $226 | (1 of 7) |
| | Rating Area 3: DC Suburbs | Kaiser Permanente | $270 | (4 of 5) | $226 | (1 of 7) |
| Michigan | Rating Area 1: Detroit | McLaren Health Plan | $288 | (4 of 9) | $309 | (10 of 12) |
| | | HAP | $302 | (5 of 9) | $266 | (6 of 12) |
| | | Priority Health | $313 | (7 of 9) | $286 | (7 of 12) |
| | Rating Area 7: Lansing | McLaren Health Plan | $278 | (2 of 5) | $296 | (4 of 7) |
| | | Priority Health | $326 | (4 of 5) | $303 | (5 of 7) |
| | | Physicians Health Plan | N/A | | $271 | (1 of 7) |
| | Rating Area 15: Rural | Priority Health | $276 | (2 of 3) | $271 | (1 of 5) |
| | | McLaren Health Plan | N/A | | $274 | (3 of 5) |
| Minnesota | Rating Area 8: Minneapolis | PreferredOne | $154 | (1 of 5) | N/A | |
| New Mexico | Rating Area 1: Albuquerque | Presbyterian Health Plan | $221 | (4 of 4) | $227 | (4 of 5) |
| | Rating Area 5: Rural | Presbyterian Health Plan | $265 | (2 of 4) | $273 | (4 of 4) |
| New York | Ratng Area 4: New York City | NorthShoreLIJ | $420 | (7 of 10) | $394 | (6 of 12) |
| | Rating Area 7: Rural | CDPHP | $493 | (4 of 5) | $499 | (6 of 7) |
| Oregon | Rating Area 1: Portland | Providence | $234 | (3 of 9) | $212 | (1 of 8) |
| | | Kaiser Permanente | $256 | (6 of 9) | $245 | (7 of 8) |
| | Rating Area 3: Salem | Kaiser Permanente | $256 | (5 of 9) | $245 | (5 of 8) |
| | | Providence | $260 | (6 of 9) | $238 | (3 of 8) |
| | Rating Area 6: Rural | Providence | N/A | | $271 | (4 of 7) |
| Pennsylvania | Rating Area 4: Pittsburgh | UPMC Health Plan | $288 | (3 of 3) | $170 | (1 of 5) |
| | Rating Area 5: Rural | Geisinger Health Plan | $214 | (2 of 4) | $243 | (4 of 6) |
| | | UPMC Health Plan | $320 | (4 of 4) | $228 | (3 of 6) |
| Rhode Island | Entire State | Neighborhood Health Plan | $296 | (2 of 2) | $244 | (1 of 3) |
| Texas | Rating Area 8: Dallas | Scott and White Health Plan | N/A | | $292 | (4 of 7) |
| | Rating Area 19: San Antonio | CommunityFirst | $386 | (5 of 5) | $239 | (3 of 8) |
| Virginia | Rating Area 7: Richmond | Optima Health Plan | $348 | (4 of 4) | $377 | (3 of 3) |
| | Rating Area 9: Virginia Beach | Optima Health Plan | $272 | (1 of 2) | $285 | (1 of 2) |
| | Rating Area 12: Rural | Optima Health Plan | $320 | (3 of 3) | $346 | (3 of 3) |
| | Rating Area 10: Northern Virginia | Innovation Health Insurance Company | $259 | (1 of 5) | $282 | (2 of 5) |
| | | Kaiser Permanente | $275 | (3 of 5) | $273 | (1 of 5) |
| Wisconsin | Rating Area 1: Milwaukee | Arise Health Plan | $339 | (3 of 4) | $366 | (5 of 6) |
| | Rating Area 10: Rural | Arise Health Plan | $287 | (1 of 3) | $302 | (1 of 5) |
| | | Security Health Plan | $301 | (2 of 3) | $307 | (2 of 5) |

Sources: Healthcare.gov for the Federally Facilitated Marketplaces, Federally Facilitated Marketplace – Partnership states, and Federally Supported State Based Marketplaces. State Based Marketplace data is from the respective State Based Marketplace websites.

*Notes: Premium information displayed is for a 40 year old individual, non-smoker. The premium price shown is for the lowest cost silver offering for the given insurer. The number displayed in parentheses is the pricing position of the given insurer's lowest cost silver option in relation to the other insurers' lowest cost silver options in that market.*

- The University of Arizona Health Plans improved their competitive premium positioning in both the Phoenix and Tucson markets in 2015 after a far less competitive start in 2014.
- Preferred One offered the lowest-cost silver plan in the Minneapolis market in 2014, earning it substantial market share. However, citing substantial financial losses, the insurer left the marketplace in 2015.
- Kaiser Permanente is among the lowest-cost insurers in Baltimore, Northern Virginia and and San Francisco in 2015, having improved the relative premiums for its lowest-cost silver options in the second year of reform. However, they are less price competitive in Denver; Atlanta; and Portland, Oregon.
- The Neighborhood Health Plan's lowest-cost silver plan was the higher of the two insurers participating in Rhode Island's marketplace in 2014, but it is the lowest cost of the three insurers participating in 2015.
- The Innovation Health plan, the product of the INOVA Health System, offered the lowest-cost silver plan in Northern Virginia in 2014 and ranked second lowest in cost in 2015. Optima Health, the product of the Sentara Healthcare system, offered the lowest-cost silver plan in the Virginia Beach area in both 2014 and 2015.
- In contrast, the Geisinger Health Plan, a highly regarded integrated system, is not competitively priced in the central Pennsylvania market. Similarly, the McLaren Health Plan, Health Alliance Plan and Priority Health in Detroit and Lansing, Michigan, were among the higher premium offerings in those markets. The Presbyterian Health Plan was among the highest premium insurers in the two New Mexico markets that we examined. North Shore-LIJ's lowest-premium silver plans were in the middle among the many insurer offerings in New York City.

## Co-ops: New insurers That Are Expanding and Improving Their Competitive Pricing Position With Time

Co-ops participated in 26 of the 73 rating regions we studied in 2014 and expanded into six additional rating regions in 2015 (Table 7). Two co-ops each left one of their rating regions in 2015, but a competing co-op remained in the two markets, Denver, Colorado, and Salem, Oregon. In 2014, nine co-ops in the 26 rating regions were either the lowest- or second-lowest-priced silver insurers. In 2015, however, there were 36 co-ops operating in 32 rating regions. Of these, 22 held the most price competitive positions, signifying a substantial increase in their competitiveness.

Co-ops that offered marketplace coverage in both 2014 and 2015 were more likely to improve their competitive pricing positions in the second year than they were to have their pricing position worsen or stay the same as in 2014. In 16 cases, co-ops' premium ranking improved relative to that of other insurers. In six cases co-ops' pricing position worsened; in seven they stayed the same (in two of these seven, however, the co-ops were already the lowest-priced silver plan insurer in 2014). In every case where a co-op improved its competitive pricing position in 2015, they did so by lowering the premium of their lowest-cost silver plan. In four of the six cases where the co-ops competitive pricing position worsened, this happened despite the fact that the co-op had lowered their lowest-cost silver plan premium or increased it by only 1 percent (in the other two cases the co-op had increased their lowest-priced option price by 8 percent).

Some specific examples of co-op experience in the marketplace arena include:

- In 2014, Illinois's co-op, Land of Lincoln Health, was the third-lowest-priced insurer in the Chicago area and the rural area we studied in Illinois. Land of Lincoln lowered the premiums of its lowest-cost silver plans in both regions in 2015, such that it now offers the lowest-premium silver plan in both markets.
- InHealth Mutual entered the Ohio markets of Columbus, Cincinnati and the rural Ohio area we studied in 2015, setting premiums that place the insurer in the middle of the competitive pack in all three rating regions.
- Colorado HealthOP was the third-lowest-priced insurer of 10 insurers in Denver, the third-lowest of four insurers in Grand Junction, and the sixth-lowest of seven in Colorado Springs in 2014. In 2015, however, the co-op aggressively lowered its premiums for its lowest-cost silver plan in all three areas, reducing them by 24 percent, 22 percent and 37 percent, respectively. Consequently, Colorado HealthOP was the lowest-cost insurer in Denver and Colorado Springs and the second-lowest-cost insurer in Grand Junction in the second year of reform. Another co-op in Colorado, Colorado Choice Health Plan, was the fifth-lowest-priced insurer in Denver in 2014 and left that market in 2015. It has also become less competitive in Colorado Springs in 2015, despite keeping its lowest-cost premium in that region essentially the same as in 2014.

# Table 7: Lowest Cost Silver Premium Pricing for Co-Ops in Selected States and Regions

| State | Rating Area | Carrier Name | 2014 Pricing Position | | 2015 Pricing Position | |
|---|---|---|---|---|---|---|
| Colorado | Rating Area 3: Denver | Colorado HealthOP | $273 | (3 of 10) | $207 | (1 of 8) |
| | | Colorado Choice Health Plan | $294 | (5 of 10) | N/A | |
| | Rating Area 5: Grand Junction | Colorado HealthOP | $408 | (3 of 4) | $317 | (2 of 4) |
| | Rating Area 2: Colorado Springs | Colorado Choice Health Plan | $264 | (2 of 7) | $267 | (5 of 7) |
| | | Colorado HealthOP | $309 | (6 of 7) | $194 | (1 of 7) |
| Connecticut | Rating Area 1: Bridgeport | Healthy CT | $436 | (3 of 3) | $380 | (1 of 4) |
| | Rating Area 2: Hartford | Healthy CT | $363 | (3 of 3) | $333 | (2 of 4) |
| Illinois | Rating Area 1: Chicago | Land of Lincoln Mutual Health Insurance Co. | $314 | (3 of 7) | $212 | (1 of 7) |
| | Rating Area 13: Rural | Land of Lincoln Mutual Health Insurance Co. | $353 | (3 of 3) | $290 | (1 of 4) |
| Louisiana | Rating Area 1: New Orleans | Louisiana Health Cooperative | $361 | (4 of 4) | $370 | (4 of 5) |
| | Rating Area 5: Baton Rouge | Louisiana Health Cooperative | $285 | (1 of 4) | $308 | (2 of 4) |
| | Rating Area 7: Rural | Louisiana Health Cooperative | $358 | (3 of 3) | $355 | (2 of 4) |
| Maine | Rating Area 1: Portland | Maine Community Health Options | $284 | (1 of 2) | $282 | (2 of 3) |
| | Rating Area 3: Rural | Maine Community Health Options | $325 | (1 of 2) | $323 | (1 of 3) |
| Maryland | Rating Area 1: Baltimore | Evergreen Cooperative | $252 | (3 of 5) | $235 | (2 of 7) |
| | Rating Area 3: DC Suburbs | Evergreen Cooperative | $239 | (3 of 5) | $231 | (3 of 7) |
| | Rating Area 2: Rural | Evergreen Cooperative | $239 | (3 of 4) | $237 | (1 of 5) |
| Michigan | Rating Area 1: Detroit | Consumers Mutual Insurance of Michigan | $404 | (9 of 9) | $348 | (12 of 12) |
| | Rating Area 7: Lansing | Consumers Mutual Insurance of Michigan | $411 | (5 of 5) | $295 | (3 of 7) |
| | Rating Area 15: Rural | Consumers Mutual Insurance of Michigan | N/A | | $343 | (5 of 5) |
| New Hampshire | Entire State | Minuteman Health, Inc. | N/A | | $238 | (1 of 5) |
| | | Community Health Options | N/A | | $305 | (4 of 5) |
| New Jersey | Entire State | Health Republic Insurance of New Jersey | $401 | (3 of 3) | $315 | (1 of 5) |
| New Mexico | Rating Area 1: Albuquerque | New Mexico Health Connections | $218 | (3 of 4) | $178 | (2 of 5) |
| | Rating Area 5: Rural | New Mexico Health Connections | $266 | (3 of 4) | $239 | (2 of 4) |
| New York | Rating Aea 4: New York City | HealthRepublic | $365 | (2 of 10) | $380 | (2 of 12) |
| | Rating Area 2: Buffalo | HealthRepublic | $275 | (1 of 5) | $262 | (1 of 6) |
| | Rating Area 7: Rural | HealthRepublic | N/A | | $488 | (4 of 7) |
| Ohio | Rating Area 9: Columbus | InHealth Mutual | N/A | | $307 | (4 of 8) |
| | Rating Area 4: Cincinnati | InHealth Mutual | N/A | | $300 | (7 of 11) |
| | Rating Area 2: Rural | InHealth Mutual | N/A | | $326 | (2 of 5) |
| Oregon | Rating Area 1: Portland | HealthRepublic | $256 | (6 of 9) | $217 | (3 of 8) |
| | | Oregon's Health CO-OP | $271 | (8 of 9) | $224 | (4 of 8) |
| | Rating Area 3: Salem | HealthRepublic | $223 | (2 of 9) | $241 | (4 of 8) |
| | | Oregon's Health CO-OP | $271 | (7 of 9) | N/A | |
| | Rating Area 6: Rural | HealthRepublic | $231 | (2 of 6) | $237 | (2 of 7) |
| | | Oregon's Health CO-OP | $331 | (5 of 6) | $292 | (6 of 7) |
| Wisconsin | Rating Area 1: Milwaukee | Common Ground Healthcare Cooperative | $316 | (2 of 4) | $333 | (2 of 6) |

Sources: Healthcare.gov for the Federally Facilitated Marketplaces, Federally Facilitated Marketplace – Partnership states, and Federally Supported State Based Marketplaces. State Based Marketplace data is from the respective State Based Marketplace websites.

*Notes: Premium information displayed is for a 40 year old individual, non-smoker. The premium price shown is for the lowest cost silver offering for the given insurer. The number displayed in parentheses is the pricing position of the given insurer's lowest cost silver option in relation to the other insurers' lowest cost silver options in that market.*

# CONCLUSION

In this paper, we have provided evidence on which kinds of insurers are pricing aggressively and keeping premiums in marketplaces low and increasing slowly (from 2014 to 2015). The type of insurers offering the lowest-premium silver plan varies considerably across markets.

Blue Cross Blue Shield insurers are highly competitive in many regions, either because they have near monopoly status with few competitors, because they price aggressively in more competitive markets, or they offer separate limited network products to allow them to compete in the marketplaces. But we found that there are also many rating areas in which they have not priced competitively, and their competitive positioning worsened significantly in 2015 compared to 2014. Medicaid insurers often offer plans that fall among the lowest premiums, if not the lowest, in the areas in which they participate. Medicaid insurers are generally among the lowest-priced insurers in the marketplace in New York City and many parts of New York state. National Medicaid insurers, such as Centene and Molina, offer products that are highly competitive in many markets.

Some co-ops, such as the Land of Lincoln in Illinois and the Colorado Health Cooperative in Colorado, are highly price competitive, but other co-ops have not done as well. Some provider-sponsored insurers have offered plans with competitive premiums; this includes INOVA in Northern Virginia; Optima in the Norfolk-Virginia Beach area; the Neighborhood Health Plan in Rhode Island; and Kaiser Permanente in Baltimore, the Virginia Suburbs of Washington, D.C., and San Francisco. National insurers, with the exception of Humana, have generally not priced aggressively, though their participation in marketplaces is increasing significantly. Similarly, regional insurers, with the exception of Moda in Oregon, have not frequently been among the lowest-priced offerors, and their positioning tended to worsen in 2015.

Going forward into 2016, there have been several reports of insurers requesting large premium increases.[10] Having just recently had a chance to analyze their nongroup insurance claims experience in 2014, some insurers report that they had a higher-than-expected volume of claims that year. At this point they do not know how they will be compensated by risk adjustment or risk corridors. Insurers with a bad 2014 experience could well seek large rate increases to protect against continuing losses. They may be attempting to price cautiously without leaving the marketplace. It is important to remember that at this time, these rate increases are merely requests, with the state rate review processes yet to take place. State departments of insurance have the ability to deny these requests after review of insurer data. Consequently, the number of markets in which insurers will obtain substantial premium increases and the pricing behavior of the other insurers' in those markets are uncertain at this time. For example, even if one insurer increases its premiums substantially, if there are substantially lower-cost options or if that insurer did not have much market share, the premium increase may not have much effect on that market.

Though 2016 pricing is uncertain at this point, we do know that marketplaces are by and large the only growth market for insurers. The employer-sponsored insurance market has been slowly declining for many years. Health care cost growth has been low and thus would not be a driver of large premium increases. The ACA's incentives for insurers to offer one of the two lowest-cost silver plans in the markets in which they participate remain in place. Even individuals receiving tax credits who choose a plan that costs more than the second-lowest-cost silver option must pay the full marginal cost of the higher premium. As a consequence, any insurer that chooses to be cautious and set high rates may well avoid losses, but is also likely to have a small market share.

It is likely that the Medicaid insurers will play an increasingly important role in many markets, as will some of the co-ops. Though Blue Cross Blue Shield insurers have shown that they can drive premium competition in some areas, in the growing number of areas where they do not, their competitors are likely to grow. Provider-sponsored insurers also look increasingly strong in some areas. If and when marketplace enrollment increases further and the collective market successfully obtains a better balance of health care risk, many of the national and regional insurers, as well as the remaining Blue Cross Blue Shield insurers, could compete more aggressively. But for the moment, many of these seem content to participate in the marketplace but compete on brand name rather than price.

# ENDNOTES


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2. Holahan J, Blumberg LJ and Wengle E. "Marketplace Premium Changes Throughout the United States." This estimate is a rating region population weighted average over every rating region in the U.S.
3. See for example, Radnofsky L and Armour S, "More Health-Care Insurers Seek Big Premium Increases," *Wall Street Journal,* last updated Monday, June 1, 2015, http://www.wsj.com/articles/more-health-care-insurers-seek-big-premium-increases-1433206078?tesla=y (Accessed June 2015); Klein P, "Rate Hikes Expose Shaky Foundation of Obamacare," *Washington Examiner,* Thursday, May 21, 2015, http://www.washingtonexaminer.com/article/2564841 (Accessed May 2015); Abelson R, "Seeking Rate Increases, Insurers Use Guesswork," *New York Times,* Monday, June 1 2015, http://www.nytimes.com/2015/06/02/business/seeking-rate-increases-insurers-use-guesswork.html?_r=0 (Accessed June 2015).
4. Pearson, C, "Lowest-Cost Exchange Premiums Remain Competitive in 2016; Consumers may be able to keep increases small by selecting a low-cost silver option." Washington, DC: Avalere Health. June 2015. http://avalere.com/expertise/managed-care/insights/lowest-cost-exchange-premiums-remain-competitive-in-2016-consumers-may-be-a (accessed June 2015).
5. Burke A, Misra A and Sheingold S. "Premium Affordability, Competition, and Choice in the Health Insurance Marketplace, 2014." Washington: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 2014, http://aspe.hhs.gov/health/reports/2014/Premiums/2014MktPlacePremBrf.pdf.
6. We do not count as exits situations where insurers merged between the 2014 and 2015 data. Mergers included Aetna with Coventry and Health America Pennsylvania, and United Healthcare with All Savers.
7. "Multi-State Plan Program and the Health Insurance Marketplace," U.S. Office of Personnel Management, http://www.opm.gov/healthcare-insurance/multi-state-plan-program/ (accessed June 2015).
8. Blue Shield plans originally offered insurance coverage for physician care and Blue Cross plans did so for hospital care. Over time, in the vast majority of cases, the Blue Shield insurer and the Blue Cross insurer in a state merged to provide insurance coverage for both types of services.
9. Neighborhood Health Plan also operates in Massachusetts, a state not included in our study.
10. See for example, Radnofsky and Armour, "More Health-Care Insurers Seek Big Premium Increases"; Klein , "Rate Hikes Expose Shaky Foundation of Obamacare;"; Abelson, "Seeking Rate Increases, Insurers Use Guesswork"

# Appendix A-1. Lowest Cost Silver Premium Pricing by Insurer for Selected States, Regions: 2014-2015

| Rating Area | Insurer Name | Insurer Type | 2014 Pricing Position | | 2015 Pricing Position | |
|---|---|---|---|---|---|---|
| **Alabama** | | | | | | |
| Rating Area 3: Birmingham | Humana Insurance Company | National | $255 | (1) | $262 | (1) |
| | Blue Cross and Blue Shield of Alabama | Blue | $258 | (2) | $280 | (3) |
| | UnitedHealthcare | National | N/A | | $264 | (2) |
| Rating Area 13: Rural | Blue Cross and Blue Shield of Alabama | Blue | $234 | (1) | $254 | (1) |
| | UnitedHealthcare | National | N/A | | $260 | (2) |
| **Arizona** | | | | | | |
| Rating Area 4: Phoenix | Health Net of Arizona, Inc. | Regional | $194 | (1) | $222 | (4) |
| | Meritus Health Partners | Medicaid | $214 | (2) | $166 | (1) |
| | Humana Health Plan, Inc. | National | $218 | (3) | $265 | (9) |
| | Blue Cross Blue Shield of Arizona, Inc. | Blue | $252 | (4) | $240 | (5) |
| | Aetna | National | $260 | (5) | $257 | (7) |
| | Health Choice Insurance Co. | Medicaid | $283 | (6) | $195 | (2) |
| | Cigna Healthcare | National | $306 | (7) | $350 | (11) |
| | University of Arizona Health Plans – University Healthcare Marketplace | Provider | $325 | (8) | $202 | (3) |
| | Phoenix Health Plan | Medicaid | N/A | | $252 | (6) |
| | United Healthcare | National | N/A | | $262 | (8) |
| | Assurant Health | National | N/A | | $314 | (10) |
| Rating Area 6: Tuscon | Health Net of Arizona, Inc. | Regional | $166 | (1) | $191 | (3) |
| | Humana Health Plan, Inc. | National | $198 | (2) | $238 | (8) |
| | Blue Cross Blue Shield of Arizona, Inc. | Blue | $209 | (3) | $200 | (4) |
| | Meritus Health Partners | Medicaid | $234 | (4) | $170 | (1) |
| | Health Choice Insurance Co. | Medicaid | $247 | (5) | $232 | (7) |
| | Aetna | National | $260 | (6) | $221 | (6) |
| | Cigna Healthcare | National | $271 | (7) | $290 | (9) |
| | University of Arizona Health Plans – University Healthcare Marketplace | Provider | $290 | (8) | $189 | (2) |
| | United Healthcare | National | N/A | | $217 | (5) |
| | Assurant Health | National | N/A | | $313 | (10) |
| **Arkansas** | | | | | | |
| Rating Area 1: Little Rock | Arkansas Blue Cross and Blue Shield | Blue | $294 | (1) | $294 | (1) |
| | QualChoice Health Insurance | Regional | $322 | (2) | $372 | (3) |
| | Ambetter of Arkansas | Medicaid | $328 | (3) | $332 | (2) |
| Rating Area 6: Rural | Arkansas Blue Cross and Blue Shield | Blue | $294 | (1) | $295 | (2) |
| | Ambetter of Arkansas | Medicaid | N/A | | $291 | (1) |
| | QualChoice | Regional | N/A | | $410 | (3) |

# Appendix A-2. Lowest Cost Silver Premium Pricing by Insurer for Selected States, Regions: 2014-2015

| Rating Area | Insurer Name | Insurer Type | 2014 Pricing Position | | 2015 Pricing Position | |
|---|---|---|---|---|---|---|
| **California** | | | | | | |
| Rating Area 15: Los Angeles 1 | Health Net | Regional | $222 | (1) | $230 | (1) |
| | LA Care | Regional | $253 | (2) | $265 | (4) |
| | Blue Shield of California | Blue | $255 | (3) | $270 | (5) |
| | Anthem Blue Cross | Blue | $257 | (4) | $257 | (2) |
| | Molina | Medicaid | $262 | (5) | $259 | (3) |
| | Kaiser Permanente | Provider | $297 | (6) | $287 | (6) |
| | Anthem (MSP) | Blue | N/A | | $296 | (7) |
| Rating Area 16: Los Angeles 2 | Health Net | Regional | $242 | (1) | $247 | (1) |
| | Anthem Blue Cross | Blue | $262 | (2) | $270 | (3) |
| | Molina | Medicaid | $262 | (3) | $259 | (2) |
| | LA Care | Regional | $265 | (4) | $278 | (4) |
| | Blue Shield of California | Blue | $290 | (5) | $308 | (6) |
| | Kaiser Permanente | Provider | $328 | (6) | $300 | (5) |
| | Anthem (MSP) | Blue | N/A | | $336 | (7) |
| Rating Area 4: San Francisco | Chinese Community Health Plan | Regional | $328 | (1) | $356 | (1) |
| | Anthem Blue Cross | Blue | $377 | (2) | $414 | (4) |
| | Blue Shield of California | Blue | $378 | (3) | $401 | (3) |
| | Kaiser Permanente | Provider | $387 | (4) | $393 | (2) |
| | Health Net | Regional | $423 | (5) | $449 | (5) |
| Rating Area 1: Rural | Anthem Blue Cross | Blue | $312 | (1) | $325 | (1) |
| | Blue Shield of California | Blue | $322 | (2) | $341 | (2) |
| | Kaiser Permanente | Provider | $350 | (3) | $356 | (3) |
| **Colorado** | | | | | | |
| Rating Area 3: Denver | Kaiser Permanente | Provider | $245 | (1) | $272 | (3) |
| | Humana | National | $250 | (2) | $242 | (2) |
| | Colorado HealthOP | Co-Op | $273 | (3) | $207 | (1) |
| | Denver Health Medical Plan | Provider | $275 | (4) | $318 | (6) |
| | Colorado Choice Health Plan | Co-Op | $294 | (5) | N/A | |
| | Rocky Mountain Health Plans | Regional | $309 | (6) | $336 | (7) |
| | Cigna Healthcare | National | $318 | (7) | $339 | (8) |
| | HMO Colorado (Anthem) | Blue | $320 | (8) | $316 | (5) |
| | All-Savers | National | $381 | (9) | N/A | |
| | New Health Ventures (Access Health Colorado) | Regional | $454 | (10) | $274 | (4) |
| Rating Area 5: Grand Junction | Rocky Mountain Health Plans | Regional | $285 | (1) | $286 | (1) |
| | HMO Colorado (Anthem) | Blue | $359 | (2) | $359 | (3) |
| | Colorado HealthOP | Co-Op | $408 | (3) | $317 | (2) |
| | New Health Ventures (Access Health Colorado) | Regional | $503 | (4) | $396 | (4) |
| Rating Area 2: Colorado Springs | Humana | National | $242 | (1) | $233 | (2) |
| | Colorado Choice Health Plan | Co-Op | $264 | (2) | $267 | (5) |
| | Kaiser Permanente | Provider | $270 | (3) | $257 | (4) |
| | Rocky Mountain Health Plans | Regional | $274 | (4) | $304 | (7) |
| | HMO Colorado (Anthem) | Blue | $300 | (5) | $296 | (6) |
| | Colorado HealthOP | Co-Op | $309 | (6) | $194 | (1) |
| | New Health Ventures (Access Health Colorado) | Regional | $416 | (7) | $251 | (3) |
| **Connecticut** | | | | | | |
| Rating Area 1: Bridgeport | Connecticare | Regional | $383 | (1) | $395 | (2) |
| | Anthem Blue Cross Blue Shield | Blue | $421 | (2) | $422 | (4) |
| | Healthy CT | Co-Op | $436 | (3) | $380 | (1) |
| | United Healthcare | National | N/A | | $407 | (3) |
| Rating Area 2: Hartford | Connecticare | Regional | $316 | (1) | $321 | (1) |
| | Anthem Blue Cross Blue Shield | Blue | $328 | (2) | $334 | (3) |
| | Healthy CT | Co-Op | $363 | (3) | $333 | (2) |
| | United Healthcare | National | N/A | | $386 | (4) |

# Appendix A-3. Lowest Cost Silver Premium Pricing by Insurer for Selected States, Regions: 2014-2015

| Rating Area | Insurer Name | Insurer Type | 2014 Pricing Position | | 2015 Pricing Position | |
|---|---|---|---|---|---|---|
| **Florida** | | | | | | |
| Rating Area 43: Miami | Preferred Medical Plan, Inc. | Medicaid | $247 | (1) | $350 | (5) |
| | Coventry Health Care of Florida, Inc. | National | $269 | (2) | $309 | (4) |
| | Humana Medical Plan, Inc. | National | $274 | (3) | $301 | (3) |
| | Molina Healthcare of Florida, Inc | Medicaid | $309 | (4) | $274 | (2) |
| | Aetna | National | $318 | (5) | N/A | |
| | Florida Blue (BlueCross BlueShield FL) | Blue | $319 | (6) | $363 | (6) |
| | Ambetter from Sunshine Health | Medicaid | $345 | (7) | $274 | (1) |
| | Cigna Healthcare | National | $351 | (8) | $419 | (8) |
| | Florida Blue HMO (a BlueCross BlueShield FL company) | Blue | $357 | (9) | $430 | (9) |
| | Assurant Health | National | N/A | | $397 | (7) |
| Rating Area 15: Jacksonville | Coventry Health Care of Florida, Inc. | National | $227 | (1) | $271 | (1) |
| | Florida Blue (BlueCross BlueShield FL) | Blue | $256 | (2) | $291 | (3) |
| | Florida Blue HMO (a BlueCross BlueShield FL company) | Blue | $282 | (3) | N/A | |
| | Aetna | National | $338 | (4) | N/A | |
| | Assurant Health | National | N/A | | $333 | (4) |
| | UnitedHealthcare | National | N/A | | $280 | (2) |
| Rating Area 12: Rural | Florida Blue HMO (a BlueCross BlueShield FL company) | Blue | $269 | (1) | $333 | (2) |
| | Florida Blue (BlueCross BlueShield FL) | Blue | $290 | (2) | $347 | (4) |
| | UnitedHealthcare | National | N/A | | $296 | (1) |
| | Assurant Health | National | N/A | | $333 | (2) |
| **Georgia** | | | | | | |
| Rating Area 3: Atlanta | Humana Employers Health Plan of Georgia, Inc. | National | $229 | (1) | $257 | (3) |
| | Kaiser Permanente | Provider | $297 | (2) | $323 | (7) |
| | Ambetter from Peach State Health Plan | Medicaid | $301 | (3) | $255 | (2) |
| | Blue Cross and Blue Shield of Georgia | Blue | $311 | (4) | $285 | (4) |
| | Coventry Health Care of Georgia, Inc. | National | N/A | | $248 | (1) |
| | Anthem Blue Cross and Blue Shield | Blue | N/A | | $319 | (5) |
| | UnitedHealthcare | National | N/A | | $320 | (6) |
| | Cigna Healthcare | National | N/A | | $326 | (8) |
| | Assurant Health | National | N/A | | $363 | (9) |
| Rating Area 10: Rural | Humana Employers Health Plan of Georgia, Inc. | National | $229 | (1) | $259 | (1) |
| | Blue Cross and Blue Shield of Georgia | Blue | $295 | (2) | $269 | (3) |
| | Kaiser Permanente | Provider | $297 | (3) | $323 | (6) |
| | Alliant Health Plans | Provider | $319 | (4) | $295 | (4) |
| | Coventry Health Care of Georgia, Inc. | National | N/A | | $266 | (2) |
| | Anthem Blue Cross and Blue Shield | Blue | N/A | | $302 | (5) |
| | UnitedHealthcare | National | N/A | | $340 | (7) |
| | Assurant Health | National | N/A | | $390 | (8) |
| **Illinois** | | | | | | |
| Rating Area 1: Chicago | Blue Cross Blue Shield of Illinois | Blue | $210 | (1) | $215 | (2) |
| | Humana Health Plan, Inc. | National | $262 | (2) | $288 | (5) |
| | Land of Lincoln Mutual Health Insurance Company | Co-Op | $314 | (3) | $212 | (1) |
| | Coventry Health Care | National | $334 | (4) | $330 | (6) |
| | Aetna | National | $383 | (5) | $458 | (7) |
| | IlliniCare Health | Medicaid | N/A | (6) | $221 | (3) |
| | UnitedHealthcare | National | N/A | (7) | $279 | (4) |
| Rating Area 13: Rural | Blue Cross Blue Shield of Illinois | Blue | $278 | (1) | $298 | (3) |
| | Health Alliance Medical Plans, Inc. | Provider | $301 | (2) | $293 | (2) |
| | Land of Lincoln Mutual Health Insurance Company | Co-Op | $353 | (3) | $290 | (1) |
| | Coventry Health Care | National | N/A | | $348 | (4) |

# Appendix A-4. Lowest Cost Silver Premium Pricing by Insurer for Selected States, Regions: 2014-2015

| Rating Area | Insurer Name | Insurer Type | 2014 Pricing Position | | 2015 Pricing Position | |
|---|---|---|---|---|---|---|
| **Indiana** | | | | | | |
| Rating Area 10: Indianapolis | Anthem Blue Cross and Blue Shield | Blue | $339 | (1) | $351 | (3) |
| | MDwise Marketplace | Medicaid | $356 | (2) | $365 | (4) |
| | Ambetter from MHS | Medicaid | N/A | | $329 | (2) |
| | UnitedHealthcare | National | N/A | | $386 | (5) |
| | Assurant Health | National | N/A | | $525 | (6) |
| | CareSource Just4Me | Medicaid | N/A | | $317 | (1) |
| Rating Area 3: Rural | PHP | Provider | $298 | (1) | $337 | (2) |
| | Ambetter from MHS | Medicaid | $334 | (2) | $285 | (1) |
| | Anthem Blue Cross and Blue Shield | Blue | $339 | (3) | $338 | (3) |
| | UnitedHealthcare | National | N/A | | $339 | (4) |
| | Assurant Health | National | N/A | | $487 | (5) |
| **Lousiana** | | | | | | |
| Rating Area 1: New Orleans | HMO Louisiana | Blue | $295 | (1) | $297 | (2) |
| | Vantage Health Plan, Inc. | Regional | $313 | (2) | $358 | (3) |
| | Blue Cross Blue Shield of Louisiana | Blue | $324 | (3) | $384 | (5) |
| | Louisiana Health Cooperative | Co-Op | $361 | (4) | $370 | (4) |
| | UnitedHealthcare | National | N/A | | $296 | (1) |
| Rating Area 5: Baton Rouge | Louisiana Health Cooperative | Co-Op | $285 | (1) | $308 | (2) |
| | HMO Louisiana | Blue | $291 | (2) | $293 | (1) |
| | Vantage Health Plan, Inc. | Regional | $313 | (3) | $358 | (3) |
| | Blue Cross Blue Shield of Louisiana | Blue | $330 | (4) | $392 | (4) |
| Rating Area 7: Rural | Vantage Health Plan, Inc. | Regional | $313 | (1) | $358 | (3) |
| | Blue Cross Blue Shield of Louisiana | Blue | $320 | (2) | $381 | (4) |
| | Louisiana Health Cooperative | Co-Op | $358 | (3) | $355 | (2) |
| | UnitedHealthcare | National | N/A | | $322 | (1) |
| **Maine** | | | | | | |
| Rating Area 1: Portland | Maine Community Health Options | Co-Op | $284 | (1) | $282 | (2) |
| | Anthem Blue Cross Blue Shield | Blue | $297 | (2) | $275 | (1) |
| | Harvard Pilgrim Health Care | Regional | N/A | | $364 | (3) |
| Rating Area 3: Rural | Maine Community Health Options | Co-Op | $325 | (1) | $323 | (1) |
| | Anthem Blue Cross Blue Shield | Blue | $364 | (2) | $343 | (2) |
| | Harvard Pilgrim Health Care | Regional | N/A | | $404 | (3) |

# Appendix A-5. Lowest Cost Silver Premium Pricing by Insurer for Selected States, Regions: 2014-2015

| Rating Area | Insurer Name | Insurer Type | 2014 Pricing Position | | 2015 Pricing Position | |
|---|---|---|---|---|---|---|
| **Maryland** | | | | | | |
| Rating Area 1: Baltimore | BlueChoice | Blue | $228 | (1) | $244 | (3) |
| | Carefirst of Maryland | Blue | $240 | (2) | $274 | (5) |
| | Evergreen Cooperative | Co-Op | $252 | (3) | $235 | (2) |
| | Kaiser Permanente | Provider | $270 | (4) | $226 | (1) |
| | All-Savers | National | $339 | (5) | $315 | (6) |
| | Cigna Healthcare | National | N/A | | $340 | (7) |
| | United Healthcare of the Mid-Atlantic | National | N/A | | $253 | (4) |
| Rating Area 3: D.C. Suburbs | BlueChoice | Blue | $213 | (1) | $227 | (2) |
| | Carefirst of Maryland | Blue | $223 | (2) | $255 | (4) |
| | Evergreen Cooperative | Co-Op | $239 | (3) | $231 | (3) |
| | Kaiser Permanente | Provider | $270 | (4) | $226 | (1) |
| | All-Savers | National | $339 | (5) | $315 | (6) |
| | Cigna Healthcare | National | N/A | | $345 | (7) |
| | United Healthcare of the Mid-Atlantic | National | N/A | | $259 | (5) |
| Rating Area 2: Rural | BlueChoice | Blue | $224 | (1) | $239 | (2) |
| | Carefirst of Maryland | Blue | $235 | (2) | $268 | (3) |
| | Evergreen Cooperative | Co-Op | $239 | (3) | $237 | (1) |
| | All-Savers | National | $339 | (4) | $315 | (4) |
| | Cigna Healthcare | National | N/A | | $345 | (5) |
| **Michigan** | | | | | | |
| Rating Area 1: Detroit | Humana Medical Plan of Michigan, Inc. | National | $190 | (1) | $219 | (1) |
| | Total Health Care USA, Inc. | Regional | $224 | (2) | $243 | (4) |
| | Blue Care Network of Michigan | Blue | $242 | (3) | $234 | (3) |
| | McLaren Health Plan | Provider | $288 | (4) | $309 | (10) |
| | HAP | Provider | $302 | (5) | $266 | (6) |
| | Blue Cross Blue Shield of Michigan | Blue | $311 | (6) | $301 | (9) |
| | Priority Health | Provider | $313 | (7) | $286 | (7) |
| | Molina Healthcare of Michigan, Inc. | Medicaid | $327 | (8) | $252 | (5) |
| | Consumers Mutual Insurance of Michigan | Co-Op | $404 | (9) | $348 | (12) |
| | UnitedHealthcare | National | N/A | | $230 | (2) |
| | Harbor Choice | Medicaid | N/A | | $301 | (8) |
| | Assurant Health | National | N/A | | $334 | (11) |
| Rating Area 7: Lansing | Blue Care Network of Michigan | Blue | $245 | (1) | $277 | (2) |
| | McLaren Health Plan | Provider | $278 | (2) | $296 | (4) |
| | Blue Cross Blue Shield of Michigan | Blue | $311 | (3) | $344 | (6) |
| | Priority Health | Provider | $326 | (4) | $303 | (5) |
| | Consumers Mutual Insurance of Michigan | Co-Op | $411 | (5) | $295 | (3) |
| | Physicians Health Plan | Provider | N/A | | $271 | (1) |
| | Assurant Health | National | N/A | | $364 | (7) |
| Rating Area 15: Rural | Blue Care Network of Michigan | Blue | $245 | (1) | $272 | (2) |
| | Priority Health | Provider | $276 | (2) | $271 | (1) |
| | Blue Cross Blue Shield of Michigan | Blue | $277 | (3) | $307 | (4) |
| | McLaren Health Plan | Provider | N/A | | $274 | (3) |
| | Consumers Mutual Insurance of Michigan | Co-Op | N/A | | $343 | (5) |
| **Missouri** | | | | | | |
| Rating Area 6: St. Louis | Coventry Health Care | National | $239 | (1) | $252 | (1) |
| | Anthem Blue Cross and Blue Shield | Blue | $263 | (2) | $289 | (3) |
| | UnitedHealthcare | National | N/A | | $284 | (2) |
| | Cigna Healthcare | National | N/A | | $291 | (4) |
| Raing Area 3: Kansas City | Coventry Health and Life | National | $238 | (1) | $258 | (3) |
| | Blue Cross and Blue Shield of Kansas City | Blue | $258 | (2) | $241 | (1) |
| | Humana Insurance Company | National | N/A | | $252 | (2) |
| Rating Area 10: Rural | Anthem Blue Cross and Blue Shield | Blue | $346 | (1) | $381 | (2) |
| | Coventry Health Care | National | $395 | (2) | $430 | (3) |
| | UnitedHealthcare | National | N/A | | $310 | (1) |

# Appendix A-6. Lowest Cost Silver Premium Pricing by Insurer for Selected States, Regions: 2014-2015

| Rating Area | Insurer Name | Insurer Type | 2014 Pricing Position | | 2015 Pricing Position | |
|---|---|---|---|---|---|---|
| **Minnesota** | | | | | | |
| Rating Area 8: Minneapolis | PreferredOne | Regional | $154 | (1) | N/A | |
| | HealthPartners | Regional | $166 | (2) | $181 | (1) |
| | Blue Cross Blue Shield Minneosta | Blue | $201 | (3) | $201 | (3) |
| | Ucare | Medicaid | $203 | (4) | $183 | (2) |
| | Medica | Medicaid | $211 | (5) | $222 | (5) |
| Rating Area 2: Duluth | HealthPartners | Regional | $213 | (1) | $235 | (2) |
| | Ucare | Medicaid | $233 | (2) | $206 | (1) |
| | Blue Cross Blue Shield Minneosta | Blue | $236 | (3) | $271 | (4) |
| | Medica | Medicaid | N/A | | $263 | (3) |
| **New Hampshire** | | | | | | |
| Rating Area 1: Entire State | Anthem Blue Cross and Blue Shield | Blue | $288 | (1) | $284 | (2) |
| | Minuteman Health, Inc. | Co-Op | N/A | | $238 | (1) |
| | Harvard Pilgrim | Regional | N/A | | $295 | (3) |
| | Community Health Options | Co-Op | N/A | | $305 | (4) |
| | Assurant Health | National | N/A | | $474 | (5) |
| **New Jersey** | | | | | | |
| Rating Area 1: Entire State | AmeriHealth New Jersey | Regional | $318 | (1) | $355 | (3) |
| | Horizon Blue Cross Blue Shield of New Jersey | Blue | $356 | (2) | $316 | (2) |
| | Health Republic Insurance of New Jersey | Co-Op | $401 | (3) | $315 | (1) |
| | Oscar | Regional | N/A | | $357 | (4) |
| | UnitedHealthcare | National | N/A | | $391 | (5) |
| **New Mexico** | | | | | | |
| Rating Area 1: Albuquerque | Blue Cross Blue Shield of New Mexico | Blue | $189 | (1) | $167 | (1) |
| | Molina Health Care of New Mexico, Inc. | Medicaid | $212 | (2) | $186 | (3) |
| | New Mexico Health Connections | Co-Op | $218 | (3) | $178 | (2) |
| | Presbyterian Health Plan | Provider | $221 | (4) | $227 | (4) |
| | CHRISTUS Health Plan | Medicaid | N/A | | $303 | (5) |
| Rating Area 5: Rural | Blue Cross Blue Shield of New Mexico | Blue | $261 | (1) | $238 | (1) |
| | Presbyterian Health Plan | Provider | $265 | (2) | $273 | (4) |
| | New Mexico Health Connections | Co-Op | $266 | (3) | $239 | (2) |
| | Molina Health Care of New Mexico, Inc. | Medicaid | $289 | (4) | $259 | (3) |

# Appendix A-7. Lowest Cost Silver Premium Pricing by Insurer for Selected States, Regions: 2014-2015

| Rating Area | Insurer Name | Insurer Type | 2014 Pricing Position | | 2015 Pricing Position | |
|---|---|---|---|---|---|---|
| **New York** | | | | | | |
| Rating Area 4: New York City | Metro Plus | Medicaid | $359 | (1) | $383 | (3) |
| | HealthRepublic | Co-Op | $365 | (2) | $380 | (2) |
| | Oscar | Regional | $385 | (3) | $394 | (6) |
| | Emblem | Regional | $385 | (4) | $407 | (8) |
| | Fidelis | Medicaid | $390 | (5) | $384 | (4) |
| | Empire Blue Cross Blue Shield | Blue | $418 | (6) | $448 | (10) |
| | NorthShoreLIJ | Provider | $420 | (7) | $394 | (6) |
| | HealthFirst | Medicaid | $440 | (8) | $387 | (5) |
| | Affinity | Medicaid | $440 | (9) | $372 | (1) |
| | United Healthcare | National | $642 | (10) | $545 | (12) |
| | MVP Health | Regional | N/A | | $472 | (9) |
| | Wellcare | Medicaid | N/A | | $417 | (11) |
| Rating Area 2: Buffalo | HealthRepublic | Co-Op | $275 | (1) | $262 | (1) |
| | Fidelis | Medicaid | $338 | (2) | $337 | (2) |
| | BlueCross Blueshield of Western New York | Blue | $372 | (3) | $342 | (3) |
| | Univera | Regional | $430 | (4) | $474 | (6) |
| | IHBC | Regional | $432 | (5) | $428 | (5) |
| | MVP Health | Regional | N/A | | $365 | (3) |
| Rating Area 7: Rural | Fidelis | Medicaid | $337 | (1) | $356 | (2) |
| | MVP Health | Regional | $373 | (2) | $431 | (3) |
| | Excellus | Blue | $443 | (3) | $488 | (4) |
| | CDPHP | Provider | $493 | (4) | $499 | (6) |
| | Blueshield of Northeastern NY | Blue | $505 | (5) | $568 | (7) |
| | HealthRepublic | Co-Op | N/A | | $488 | (4) |
| | Emblem | Regional | N/A | | $278 | (1) |
| **North Carolina** | | | | | | |
| Rating Area 4: Charlotte | Blue Cross and Blue Shield of NC | Blue | $301 | (1) | $328 | (2) |
| | Coventry Health Care of the Carolinas, Inc. | National | $307 | (2) | $324 | (1) |
| | UnitedHealthcare | National | N/A | | $340 | (3) |
| Rating Area 9: Rural | Blue Cross and Blue Shield of NC | Blue | $319 | (1) | $362 | (3) |
| | Coventry Health Care of the Carolinas, Inc. | National | $344 | (2) | $338 | (2) |
| | UnitedHealthcare | National | N/A | | $267 | (1) |
| **Ohio** | | | | | | |
| Rating Area 9: Columbus | CareSource | Medicaid | $238 | (1) | $244 | (1) |
| | Anthem Blue Cross and Blue Shield | Blue | $317 | (2) | $342 | (5) |
| | MedMutual | Regional | $354 | (3) | $352 | (6) |
| | MOLINA HEALTHCARE OF OHIO | Medicaid | $418 | (4) | $281 | (2) |
| | Aetna | National | N/A | | $303 | (3) |
| | InHealth Mutual | Co-Op | N/A | | $307 | (4) |
| | UnitedHealthcare | National | N/A | | $366 | (7) |
| | Assurant Health | National | N/A | | $435 | (8) |
| Rating Area 4: Cincinnati | Humana Health Plan of Ohio, Inc. | National | $216 | (1) | $253 | (3) |
| | CareSource | Medicaid | $238 | (2) | $232 | (1) |
| | Ambetter from Buckeye Community Health Plan | Medicaid | $262 | (3) | $236 | (2) |
| | HealthSpan | Regional | $274 | (4) | $268 | (4) |
| | Anthem Blue Cross and Blue Shield | Blue | $294 | (5) | $319 | (8) |
| | MedMutual | Regional | $359 | (6) | $353 | (10) |
| | MOLINA HEALTHCARE OF OHIO | Medicaid | $431 | (7) | $281 | (5) |
| | Aetna | National | N/A | | $298 | (6) |
| | InHealth Mutual | Co-Op | N/A | | $300 | (7) |
| | UnitedHealthcare | National | N/A | | $326 | (9) |
| | Assurant Health | National | N/A | | $478 | (11) |
| Rating Area 2: Rural | HealthSpan | Regional | $281 | (1) | $270 | (1) |
| | Anthem Blue Cross and Blue Shield | Blue | $343 | (2) | $372 | (4) |
| | MedMutual | Regional | $345 | (3) | $357 | (3) |
| | InHealth Mutual | Co-Op | N/A | | $326 | (2) |
| | Assurant Health | National | N/A | | $430 | (5) |

# Appendix A-8. Lowest Cost Silver Premium Pricing by Insurer for Selected States, Regions : 2014-2015

| Rating Area | Insurer Name | Insurer Type | 2014 Pricing Position | | 2015 Pricing Position | |
|---|---|---|---|---|---|---|
| **Oregon** | | | | | | |
| Rating Area 1: Portland | Moda | Regional | $194 | (1) | $213 | (2) |
| | Health Net | Regional | $215 | (2) | N/A | |
| | Providence | Provider | $234 | (3) | $212 | (1) |
| | Lifewise | Blue | $248 | (4) | $244 | (6) |
| | PacificSource | Regional | $248 | (4) | $250 | (8) |
| | HealthRepublic | Co-Op | $256 | (6) | $217 | (3) |
| | Kaiser Permanente | Provider | $256 | (6) | $245 | (7) |
| | Oregon's Health CO-OP | Co-Op | $271 | (8) | $224 | (4) |
| | Bridgespan | Blue | $278 | (9) | $238 | (5) |
| Rating Area 3: Salem | Moda | Regional | $201 | (1) | $221 | (1) |
| | HealthRepublic | Co-Op | $223 | (2) | $241 | (4) |
| | PacificSource | Regional | $248 | (3) | $253 | (7) |
| | Lifewise | Blue | $254 | (4) | $250 | (6) |
| | Kaiser Permanente | Provider | $256 | (5) | $245 | (5) |
| | Providence | Provider | $260 | (6) | $238 | (3) |
| | Oregon's Health CO-OP | Co-Op | $271 | (7) | N/A | |
| | ATRIO | Regional | $278 | (8) | $233 | (2) |
| | Bridgespan | Blue | $296 | (9) | $266 | (8) |
| Rating Area 6: Rural | Moda | Regional | $213 | (1) | $235 | (1) |
| | HealthRepublic | Co-Op | $231 | (2) | $237 | (2) |
| | Lifewise | Blue | $254 | (3) | $250 | (3) |
| | PacificSource | Regional | $293 | (4) | $281 | (5) |
| | Oregon's Health CO-OP | Co-Op | $331 | (5) | $292 | (6) |
| | Bridgespan | Blue | $338 | (6) | $300 | (7) |
| | Providence | Provider | N/A | | $271 | (4) |
| **Pennsylvania** | | | | | | |
| Rating Area 8: Philadelphia | Independence Blue Cross | Blue | $256 | (1) | $294 | (3) |
| | Aetna | National | $347 | (2) | $287 | (2) |
| | UnitedHealthcare | National | N/A | | $267 | (1) |
| | Assurant Health | National | N/A | | $410 | (4) |
| Rating Area 4: Pittsburgh | Highmark Inc. | Blue | $163 | (1) | $179 | (2) |
| | HealthAmerica Pennsylvania, Inc. | National | $269 | (2) | N/A | |
| | UPMC Health Plan | Provider | $288 | (3) | $170 | (1) |
| | Coventry | National | N/A | | $269 | (4) |
| | UnitedHealthcare | National | N/A | | $204 | (3) |
| | Assurant Health | National | N/A | | $306 | (5) |
| Rating Area 5: Rural | Highmark Inc. | Blue | $181 | (1) | $206 | (1) |
| | Geisinger Health Plan | Provider | $214 | (2) | $243 | (4) |
| | HealthAmerica Pennsylvania, Inc. | National | $261 | (3) | N/A | |
| | UPMC Health Plan | Provider | $320 | (4) | $228 | (3) |
| | UnitedHealthcare | National | N/A | | $209 | (2) |
| | Coventry | National | N/A | | $256 | (5) |
| | Assurant Health | National | N/A | | $303 | (6) |
| **Rhode Island** | | | | | | |
| Rating Area 1: Entire State | Blue Cross Blue Shield of Rhode Island | Blue | $274 | (1) | $286 | (2) |
| | Neighborhood Health Plan | Provider | $296 | (2) | $244 | (1) |
| | United Healthcare | National | N/A | | $288 | (3) |

# Appendix A-9. Lowest Cost Silver Premium Pricing by Insurer for Selected States, Regions: 2014-2015

| Rating Area | Insurer Name | Insurer Type | 2014 Pricing Position | | 2015 Pricing Position | |
|---|---|---|---|---|---|---|
| **Texas** | | | | | | |
| Rating Area 10: Houston | Blue Cross Blue Shield of Texas | Blue | $238 | (1) | $250 | (2) |
| | Humana Health Plan of Texas, Inc. | National | $249 | (2) | $294 | (5) |
| | Cigna Healthcare | National | $289 | (3) | $339 | (7) |
| | Aetna | National | $312 | (4) | $327 | (6) |
| | Molina Marketplace | Medicaid | $313 | (5) | $268 | (4) |
| | Community Health Choice | Medicaid | $343 | (6) | $248 | (1) |
| | UnitedHealthcare | National | N/A | | $264 | (3) |
| | Assurant Health | National | N/A | | $432 | (8) |
| Rating Area 8: Dallas | Blue Cross Blue Shield of Texas | Blue | $264 | (1) | $279 | (1) |
| | Cigna Healthcare | National | $300 | (2) | $364 | (6) |
| | Molina Marketplace | Medicaid | $324 | (3) | $280 | (2) |
| | Aetna | National | $396 | (4) | $361 | (5) |
| | UnitedHealthcare | National | N/A | | $290 | (3) |
| | Scott and White Health Plan | Provider | N/A | | $292 | (4) |
| | Assurant Health | National | N/A | | $475 | (7) |
| Rating Area 19: San Antonio | Humana Health Plan of Texas, Inc. | National | $205 | (1) | $223 | (1) |
| | Blue Cross Blue Shield of Texas | Blue | $239 | (2) | $254 | (5) |
| | Aetna | National | $268 | (3) | $273 | (7) |
| | Ambetter from Superior Health Plan | Medicaid | $281 | (4) | $233 | (2) |
| | CommunityFirst | Provider | $386 | (5) | $239 | (3) |
| | UnitedHealthcare | National | N/A | | $244 | (4) |
| | Allegian Choice | Regional | N/A | | $271 | (6) |
| | Assurant Health | National | N/A | | $307 | (8) |
| **Virginia** | | | | | | |
| Rating Area 7: Richmond | Coventry Health Care of Virginia, Inc | National | $230 | (1) | $241 | (1) |
| | HealthKeepers, Inc. | Blue | $253 | (2) | $264 | (2) |
| | Aetna Life Insurance Company | National | $317 | (3) | N/A | |
| | Optima Health Plan | Provider | $348 | (4) | $377 | (3) |
| Rating Area 9: Virginia Beach | Optima Health Plan | Provider | $272 | (1) | $285 | (1) |
| | HealthKeepers, Inc. | Blue | $278 | (2) | $287 | (2) |
| Rating Area 12: Rural | Kaiser Permanente | Kaiser | $275 | (1) | $273 | (1) |
| | HealthKeepers, Inc. | Blue | $277 | (2) | $284 | (2) |
| | Optima Health Plan | Provider | $320 | (3) | $346 | (3) |
| Rating Area 10: Northern Virginia | Innovation Health Insurance Company | Provider | $259 | (1) | $282 | (2) |
| | CareFirst BlueChoice, Inc. | Blue | $272 | (2) | $323 | (4) |
| | Kaiser Permanente | Provider | $275 | (3) | $273 | (1) |
| | HealthKeepers, Inc. | Blue | $289 | (4) | $292 | (3) |
| | Group Hospitalization and Medical Services Inc. | Blue | $301 | (5) | N/A | |
| | CareFirst BlueCross BlueShield | Blue | N/A | | $347 | (5) |

# Appendix A-10. Lowest Cost Silver Premium Pricing by Insurer for Selected States, Regions: 2014-2015

| Rating Area | Insurer Name | Insurer Type | 2014 Pricing Position | | 2015 Pricing Position | |
|---|---|---|---|---|---|---|
| **Washington** | | | | | | |
| Rating Area 1: Seattle | Coordinated Care | Medicaid | $245 | (1) | $235 | (1) |
| | Group Health | Regional | $281 | (2) | $281 | (4) |
| | Premera | Blue | $283 | (3) | $291 | (7) |
| | Lifewise | Blue | $283 | (3) | $291 | (7) |
| | Bridgespan | Blue | $300 | (5) | $254 | (2) |
| | Molina | Medicaid | $311 | (6) | $277 | (3) |
| | Community Health Plans | Regional | $335 | (7) | $343 | (9) |
| | Premera (MSP) | Blue | N/A | (8) | $290 | (6) |
| | Moda | Regional | N/A | (9) | $284 | (5) |
| Rating Area 4: Spokane | Coordinated Care | Medicaid | $235 | (1) | $219 | (1) |
| | Premera | Blue | $260 | (2) | $267 | (5) |
| | Lifewise | Blue | $260 | (2) | $267 | (5) |
| | Group Health | Regional | $268 | (3) | $269 | (7) |
| | Bridgespan | Blue | $295 | (5) | $255 | (2) |
| | Community Health Plans | Regional | $322 | (6) | $332 | (9) |
| | Molina | Medicaid | $357 | (7) | $265 | (3) |
| | Premera (MSP) | Blue | N/A | | $267 | (4) |
| | Moda | Regional | N/A | | $284 | (8) |
| Rating Area 5: Rural | Coordinated Care | Medicaid | $267 | (1) | $251 | (1) |
| | Group Health | Regional | $282 | (2) | $282 | (3) |
| | Premera | Blue | $283 | (3) | $291 | (6) |
| | Lifewise | Blue | $283 | (3) | $291 | (6) |
| | Community Health Plans | Regional | $369 | (5) | $361 | (8) |
| | Bridgespan | Blue | N/A | | $263 | (2) |
| | Premera (MSP) | Blue | N/A | | $290 | (5) |
| | Moda | Regional | N/A | | $284 | (4) |
| **West Virginia** | | | | | | |
| Rating Area 2: Charleston | Highmark Blue Cross Blue Shield | Blue | $288 | (1) | $314 | (1) |
| Rating Area 9: Rural | Highmark Blue Cross Blue Shield | Blue | $262 | (1) | $286 | (1) |
| **Wisconsin** | | | | | | |
| Rating Area 1: Milwaukee | Anthem Blue Cross and Blue Shield | Blue | $302 | (1) | $348 | (3) |
| | Common Ground Healthcare Cooperative | Co-Op | $316 | (2) | $333 | (2) |
| | Arise Health Plan | Provider | $339 | (3) | $366 | (5) |
| | Molina Healthcare of Wisconsin, Inc. | Medicaid | $341 | (4) | $301 | (1) |
| | UnitedHealthcare | National | N/A | | $355 | (4) |
| | Ambetter from Managed Health Services | Medicaid | N/A | | $392 | (6) |
| Rating Area 10: Rural | Arise Health Plan | Provider | $287 | (1) | $302 | (1) |
| | Security Health Plan | Provider | $301 | (2) | $307 | (2) |
| | Anthem Blue Cross and Blue Shield | Blue | $312 | (3) | $359 | (4) |
| | Molina Healthcare of Wisconsin, Inc. | Medicaid | N/A | | $328 | (3) |
| | UnitedHealthcare | National | N/A | | $364 | (5) |

Sources: Healthcare.gov for the Federally Facilitated Marketplaces, Federally Facilitated Marketplace – Partnership states, and Federally Supported State Based Marketplaces. State Based Marketplace data is from the respective State Based Marketplace websites.

*Notes: Premium information displayed is for a 40 year old individual, non-smoker. The premium price shown is for the lowest cost silver offering for the given insurer. The number displayed in parentheses is the pricing position of the given insurer's lowest cost silver option in relation to the other insurers' lowest cost silver options in that market. The bolded number is the total number of insurers offering marketplace coverage in that rating region.*

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**Topline**

# *California's Previously Uninsured After The ACA's Second Open Enrollment Period*

## *Wave 3 of the Kaiser Family Foundation California Longitudinal Panel Survey*

**July 2015**

## METHODOLOGY

This is the third in a series of surveys by the Kaiser Family Foundation (KFF) tracking the views and experiences of a group of Californians who were uninsured in the summer of 2013, prior to implementation of the ACA's insurance market reforms and coverage expansions through Covered California and Medi-Cal. The first survey (Wave 1) was conducted from July 11-August 29, 2013, with a randomly selected group of individuals who were uninsured at the time of the interview, and was paid for entirely by KFF. The second survey (Wave 2) was conducted from April 1-June 15, 2014 and the current survey (Wave 3) was conducted from February 18-May 13, 2015, with the same longitudinal panel of respondents, whether they obtained coverage or remained uninsured. All three surveys were designed and analyzed by researchers at KFF. Social Science Research Solutions collaborated with KFF researchers on sample design, weighting, and supervised fieldwork. Fieldwork costs associated with Waves 2 and 3 of the survey were paid for by The California Endowment.

The Wave 1 survey was conducted among a representative random sample of 2,001 adults ages 19-64 living in California who reported having been without health insurance for at least two months at the time of the interview (NOTE: persons without a telephone could not be included in the random selection process). Computer-assisted telephone interviews conducted by landline (990) and cell phone (1,011, including 660 who had no landline telephone) were carried out in English and Spanish by SSRS. To increase efficiency in reaching this low-incidence, hard-to-reach group, both the landline and cell phone sampling frames oversampled areas with a lower-income population (since being uninsured is negatively correlated with income). The landline sample frame also oversampled households whose phone numbers were matched with directory listings indicating the presence of at least one person age 19-64 and a household income of less than $25,000. Additionally, 230 interviews (130 landline, 100 cell phone) were conducted with respondents who previously completed recent national SSRS omnibus surveys of the general public and indicated they were ages 19-64 and uninsured. These previous surveys were conducted with nationally representative, random-digit-dial landline and cell phone samples. Waves 2 and 3 also consisted of computer-assisted telephone interviews conducted in English and Spanish by landline and cell phone, including those who had no landline phone.

| | Total | Landline | Cell phone (no landline) | Web |
|---|---|---|---|---|
| Wave 1 (July 11-August 29, 2013) | 2,001 | 990 | 1,011 (660) | Not applicable |
| Wave 2 (April 1-June 15, 2014) | 1,219 | 623 | 545 (327) | 51 |
| Wave 3 (February 18-May 13, 2015) | 1,105 | 555 | 463 (317) | 87 |

In order to re-connect with respondents who may be more willing to complete the survey online, an abbreviated web version was introduced on for Waves 2 and 3 after attempts had been made to reach respondents by phone. The online questionnaire was offered in English and Spanish and was limited to key questions about insurance status, type of coverage, and reasons for obtaining coverage or remaining uninsured. A total of 51 respondents in Wave 2 and 87 respondents in Wave 3 completed the online version of the survey.

Screening for Waves 2 and 3 involved verifying that the respondent had participated in Wave 1. Multiple attempts were made to reach every respondent from Wave 1 and encourage participation in later waves. Efforts included multiple dialing at various times of day and throughout the week, mailings and emails to those who provided such contact information, repeated dialing of non-working numbers, and attempts to find alternative phone numbers for non-working numbers.

A multi-stage weighting design was applied to ensure accurate representation of California's nonelderly adult uninsured population prior to the ACA's coverage expansions. The weighting process for Waves 2 and 3 involved corrections for sample design, as well as sample weighting to match the weighted Wave 2 sample and the weighted Wave 3 sample to Wave 1 responses along demographic characteristics. As it did for Wave 1, the base weight for Waves 2 and 3 accounted for the oversamples used in the sample design, as well as the likelihood of non-response for the sample from earlier omnibus surveys, number of eligible household members for the landline sample, and a correction to account for the fact that respondents with both a landline and cell phone have a higher probability of selection. Demographic weighting parameters for Waves 2 and 3 were based on Wave 1 weighted demographics, which were adjusted for age, education, race/ethnicity, nativity (for Hispanics only), Hispanics by gender, presence of own child in household, marital status, California region, poverty level, and phone usage. For more information on weighting and data sources, see the Wave 1 methodology. All differences referred to in the report are statistically significant. Statistical tests of significance account for the effect of weighting, and, for trend analysis, testing takes into account the survey's panel design.

A unique consideration for panel surveys such as the Kaiser Family Foundation California Longitudinal Panel Survey, is whether those who participate in subsequent waves are different in terms of their attitudes or demographics than those who refuse to participate again or were unable to be re-contacted. Of the total 2,001 respondents who completed Wave 1, 1,219 participated in Wave 2 and 1,105 completed Wave 3. These completion rates are within an expected range given that the uninsured are already an often a difficult to reach population since many are lower income, younger, undocumented immigrants, and members of racial/ethnic minority groups, and may change phone numbers or move more often than the public at large. After data collection was complete, data from Wave 1 and Wave 3 were compared to evaluate the impact of some respondents not completing Wave 3, referred to as attrition. While there are some differences in the unweighted demographics of those who completed Wave 3 and the full Wave 1 sample, these differences are corrected for by weighting. As shown in Table 1, the total weighted distributions are similar for Wave 1 and Wave 3 for age, gender, race/ethnicity, party identification, education and income. See the Wave 3 Attrition Appendix for more information on attrition.

Another consideration for panel surveys is the potential for "sensitization effects," that is, what effect returning to the same people about the same topics has on their experiences or views. For example, after taking the baseline survey that covered many aspects of the coverage expansions under the ACA, were people more likely to seek out information about health insurance and enroll than they would have been otherwise? While there is no direct way to measure this effect on this survey, other analyses have found that these effects are minimal and short-lived,[1] and we do not believe they would have had a substantial impact on results presented here, particularly given all the other media coverage, advertising, and outreach targeted at this population during the fall and winter of 2013 and 2014.

The margin of sampling error including the design effect for the full sample is plus or minus 4 percentage points. For the recently insured, it is plus or minus 5 percentage points and for the remaining uninsured it is plus or minus 8 percentage points. For results based on other subgroups, the margin of sampling error may be higher. Sample sizes and margin of sampling errors for other subgroups are available by request. Note that sampling error is only one of many potential sources of error in this or any other public opinion poll. Kaiser Family Foundation public opinion and survey research is a charter member of the Transparency Initiative of the American Association for Public Opinion Research.

[1] M. Brodie, "Sensitization Effects in a Study of the Impact of a Nationally Broadcast Special on Health Care Reform," in Doctoral Thesis: Political Institutions, Participation, and Media Evaluations— Influences on Health Care Policy (Boston, Mass.: Harvard University, 1995).

| Table 1 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Unweighted | | | | Weighted | | | |
| | Wave 1 (n= 2001) | Completed Wave 3 (n=1105) | Completed all 3 Waves (n=923) | Percentage Point Difference (W1 – W3 Total) | Wave 1 | Completed Wave 3 | Completed all 3 Waves | Percentage Point Difference (W1 – W3 Total) |
| Gender | | | | | | | | |
| Male | 48% | 44% | 42% | 4 | 54% | 53% | 50% | 1 |
| Female | 52% | 56% | 58% | -4 | 46% | 47% | 50% | -1 |
| Race/ ethnicity | | | | | | | | |
| White | 27% | 32% | 35% | -5 | 26% | 27% | 30% | -1 |
| Black | 7% | 7% | 8% | 0 | 5% | 5% | 6% | 0 |
| Hispanic | 58% | 54% | 50% | 4 | 56% | 55% | 53% | 1 |
| Other Race | 8% | 7% | 8% | 1 | 12% | 11% | 11% | 1 |
| Age | | | | | | | | |
| 18 to 29 | 23% | 18% | 17% | 5 | 33% | 31% | 27% | 2 |
| 30 to 39 | 21% | 19% | 20% | 2 | 24% | 24% | 25% | 0 |
| 40 to 49 | 22% | 21% | 21% | 1 | 21% | 21% | 22% | 0 |
| 50 to 64 | 35% | 41% | 42% | -6 | 22% | 24% | 26% | -2 |
| Education | | | | | | | | |
| HS or less | 57% | 51% | 50% | 6 | 58% | 56% | 55% | 2 |
| Some college | 28% | 31% | 32% | -3 | 29% | 30% | 31% | -1 |
| College Grad+ | 15% | 17% | 17% | -2 | 12% | 13% | 13% | -1 |
| Phone status | | | | | | | | |
| Landline | 49% | 54% | 55% | -5 | 42% | 45% | 48% | -3 |
| Cell | 51% | 46% | 45% | 5 | 58% | 55% | 52% | 3 |
| Marital status | | | | | | | | |
| Married | 33% | 32% | 32% | 1 | 37% | 37% | 38% | 0 |
| Not Married | 67% | 67% | 68% | 0 | 62% | 63% | 62% | -1 |
| Family income | | | | | | | | |
| <138% FPL | 60% | 58% | 58% | 2 | 52% | 53% | 54% | -1 |
| 138%-400% FPL | 30% | 32% | 32% | -2 | 36% | 35% | 34% | 1 |
| 400%+ | 5% | 6% | 5% | -1 | 7% | 7% | 7% | 0 |
| Language of interview | | | | | | | | |
| English | 63% | 67% | 69% | -4 | 65% | 66% | 66% | -1 |
| Spanish | 37% | 33% | 31% | 4 | 35% | 34% | 34% | 1 |
| Resident Status | | | | | | | | |
| Citizen/ legal immigrant | 79% | 83% | 84% | -4 | 78% | 80% | 81% | -2 |
| Undocumented immigrant | 20% | 16% | 15% | 4 | 21% | 19% | 18% | 2 |
| Party Identification | | | | | | | | |
| Republican | 11% | 12% | 13% | -1 | 11% | 12% | 13% | -1 |
| Democrat | 35% | 36% | 36% | -1 | 32% | 32% | 31% | 0 |
| Independent | 35% | 35% | 34% | 0 | 37% | 39% | 38% | -2 |
| Other | 9% | 8% | 8% | 1 | 9% | 8% | 8% | 1 |

***California's Previously Uninsured After The ACA's Second Open Enrollment Period***
***Wave 2 of the Kaiser Family Foundation California Longitudinal Panel Survey***

NOTES FOR READING THE TOPLINE:
- Percentages may not always add up to 100 percent due to rounding
- Values less than 0.5 percent are indicated by an asterisk (*)
- "Vol." indicates a response was volunteered by the respondent, not offered as an explicit choice
- Questions are presented in the order asked; question numbers may not be sequential
- ‡ indicates questions asked by phone or online

Just to confirm…

S1. ‡ What is your age? (INTERVIEWER NOTE: RECORD EXACT AGE AS TWO-DIGIT CODE.)

S2. ‡ (IF REFUSED S1) Could you please tell me if you are between the ages of 19 to 24, 25 to 29, 30 to 39, 40 to 49, 50 to 64, or 65 or older?

| | Wave 3 |
|---|---|
| 19-24 | 13 |
| 25-29 | 13 |
| 30-39 | 26 |
| 40-49 | 19 |
| 50-64 | 27 |
| 65 or older | 3 |

Q6. ‡ Overall, how well would you say your health needs are being met today? Very well, somewhat well, not too well or not at all well?

| | Wave 3 | Wave 1 |
|---|---|---|
| Very well | 46 | 17 |
| Somewhat well | 34 | 37 |
| Not too well | 12 | 20 |
| Not at all well | 6 | 24 |
| Don't know | * | 1 |
| Refused | 2 | * |

QE1. Is there a place that you USUALLY go to when you are sick or need advice about your health, or not?

| | Wave 3 | Wave 1 |
|---|---|---|
| Yes | 70 | 56 |
| No | 30 | 43 |
| Don't know | * | * |
| Refused | * | - |

QE2. What kind of place is it that you usually go? Is it…?
(READ ALL OPTIONS)

*Based on total with a place they usually go when sick or needing advice about their health*

| | Wave 3 *(n=748)* | Wave 1 (*n=1216)* |
|---|---|---|
| A clinic or health center | 51 | 57 |
| A doctor's office or HMO | 31 | 18 |
| A hospital emergency room | 7 | 14 |
| An urgent care center | 5 | 5 |
| A hospital outpatient department | 2 | 2 |
| Veteran's administration medical center/hospital | 2 | 1 |
| The Internet | 1 | 1 |
| Hospital (Vol.) | - | * |
| Pharmacy (Vol.) | - | 1 |
| Across the border (Vol.) | - | 1 |
| Some other place | 1 | 1 |
| I go to more than one place (Vol.) | 1 | * |
| Don't know | - | * |
| Refused | * | * |

QE1/E2. Combo table based on total

| | Wave 3 | Wave 1 |
|---|---|---|
| Have a place they USUALLY go to | 70 | 56 |
| A clinic or health center | 35 | 32 |
| A doctor's office or HMO | 21 | 10 |
| A hospital emergency room | 5 | 8 |
| An urgent care center | 3 | 3 |
| A hospital outpatient department | 2 | 1 |
| Veteran's administration medical center/hospital | 1 | * |
| The Internet | 1 | * |
| Hospital (Vol.) | - | * |
| Pharmacy (Vol.) | - | * |
| Across the border (Vol.) | - | * |
| Some other place | 1 | 1 |
| I go to more than one place (Vol.) | 1 | * |
| Don't know/Ref kind of place | * | - |
| Do not have a place they USUALLY go to | 30 | 43 |
| Don't know | * | * |
| Refused | * | - |

T57. In the past 12 months, have you visited a doctor or health clinic, or not?

| | Wave 3 |
|---|---|
| Yes | 62 |
| No | 38 |
| Don't know | * |
| Refused | - |

Q40. In general, how (easy) or (difficult) is it for you and your family to afford [INSERT ITEMS, SCRAMBLE] – very easy, somewhat easy, somewhat difficult or very difficult? (ROTATE 1-4, 4-1 WITH ROTATES IN PARENS)

| | | Very easy | Somewhat easy | Somewhat difficult | Very difficult | Not Applicable (Vol.) | Don't know | Refused |
|---|---|---|---|---|---|---|---|---|
| a. | Food | | | | | | | |
| | Wave 3 (n=1018) | 17 | 41 | 33 | 9 | * | * | * |
| | Wave 1 (n=2001) | 18 | 34 | 38 | 10 | * | * | * |
| b. | Health care | | | | | | | |
| | Wave 3 (n=1018) | 13 | 22 | 35 | 26 | 4 | * | * |
| | Wave 1 (n=2001) | 3 | 11 | 34 | 49 | 2 | 1 | * |
| c. | Gasoline or other transportation costs | | | | | | | |
| | Wave 3 (n=1018) | 14 | 31 | 41 | 13 | 1 | * | * |
| | Wave 1 (n=2001) | 9 | 26 | 39 | 24 | 2 | * | * |
| e. | Your rent or mortgage | | | | | | | |
| | Wave 3 (n=1018) | 11 | 26 | 43 | 18 | 2 | * | 1 |
| | Wave 1 (n=2001) | 9 | 23 | 44 | 21 | 2 | * | - |
| g. | Your monthly utilities, like electricity, heat, and phone bills | | | | | | | |
| | Wave 3 (n=1018) | 13 | 33 | 40 | 13 | 1 | * | * |
| | Wave 1 (n=2001) | 11 | 27 | 43 | 18 | 1 | 1 | * |

(READ): Thinking about the 2010 health care law, also known as the Affordable Care Act and sometimes referred to as Obamacare …

T1. So far, would you say the health care law has directly (helped) you and your family, directly (hurt) you and your family, or has it not had a direct impact? (ROTATE ITEMS IN PARENTHESES)

| | Wave 3 |
|---|---|
| Helped | 30 |
| Hurt | 17 |
| No direct impact | 51 |
| Don't know | 1 |
| Refused | 1 |

B14. Since November 15th, have you been personally contacted by anyone about signing up for health insurance or Medi-Cal, through a phone call, email, text message, or door to door visit, or not?

| | Wave 3 | Wave 2[2] |
|---|---|---|
| Yes, been contacted | 26 | 26 |
| No, have not been contacted | 74 | 73 |
| Don't know | 1 | * |
| Refused | - | - |

Q52. During the past 30 days, did you see or hear any ads or commercials having to do with either the health care law, Covered California, or Medi-Cal, or not?

| | Wave 3 | Wave 1 |
|---|---|---|
| Yes, saw or heard ads | 66 | 23 |
| No, did not see or hear ads | 33 | 77 |
| Don't know | * | 1 |
| Refused | - | * |

U1.‡ Are you, yourself, now covered by any form of health insurance or health plan including a private health insurance plan, a plan through an employer, or a plan through Medi-Cal, or do you not have health insurance at this time? (READ IF NECESSARY: A health plan would include any private insurance plan through your employer or a plan that you purchased yourself, as well as a government program like Medicare or Medi-CAL)?
[INTERVIEWER NOTE: If R says they got insurance through Healthcare.gov, Obamacare, or Covered California, code as COVERED by health insurance. If respondent says they are covered by the Low Income Health Program (LIHP), code as COVERED by health insurance. If respondent says they are covered by Healthy San Francisco, code as NOT covered by health insurance. If respondent says they have Indian Health Service, code as NOT covered by health insurance.]

| | Wave 3 | Wave 2 |
|---|---|---|
| Covered by health insurance | 65 | 48 |
| Not covered by health insurance | 34 | 49 |
| Signed up but coverage hasn't started yet (Vol.) | 1 | 3 |
| Don't know | * | * |
| Refused | * | - |

B19.‡ In the past six months, have you tried to get health insurance for yourself, including private health insurance or Medi-Cal, or not?
(INTERVIEWER NOTE: If respondent says they have signed up but coverage doesn't start until a later month, code as YES, has tried to get insurance.)

*Based on total who say they are uninsured*

| | Wave 3 *(n=317)* | Wave 2[3] *(n=542)* |
|---|---|---|
| Yes, have tried to get insurance | 41 | 44 |
| No, have not tried to get insurance | 59 | 56 |
| Don't know | - | * |
| Refused | - | - |

[2] Wave 2 question read, "Since October 1st, have you been personally contacted by anyone about signing up for health insurance or Medi-Cal, through a phone call, email, text message, or door to door visit, or not?"

[3] Wave 2 question read, "Since October 1st, have you tried to get health insurance for yourself, including private health insurance or Medi-Cal, or not?"

B19A. ‡ Have you signed up for health insurance that will start next month, or not?

*Based on total who are uninsured and tried to get health insurance*

| | Wave 3 *(n=126)* | Wave 2[4] *(n=232)* |
|---|---|---|
| Yes, signed up for coverage that starts next month | 14 | 29 |
| No, have not signed up for coverage | 82 | 66 |
| Don't know | 4 | 4 |
| Refused | | - |

U1/B19/B19a. ‡ Combo table based on total

| | Wave 3 | Wave 2 |
|---|---|---|
| Covered (NET) | 68 | 58 |
| Covered by health insurance | 65 | 48 |
| Tried to get insurance and signed up for coverage that starts next month | 2 | 6 |
| Signed up but coverage hasn't started yet (Vol.) | 1 | 3 |
| Uninsured (NET) | 32 | 42 |
| Have tried to get insurance, but have not signed up | 11 | 14 |
| Have tried to get insurance, but don't know/refused if signed up | 1 | 1 |
| Have not tried to get insurance | 20 | 27 |
| Don't know/Refused if tried to get insurance | - | * |
| Don't know | * | * |
| Refused | * | - |

T3. Thinking about the past 12 months, (were you uninsured the entire time), or (did you have health insurance at some point during the past 12 months)? (ROTATE ITEMS IN PARENTHESES)

*Based on total uninsured (n=282)*

| | Wave 3 |
|---|---|
| Uninsured the entire time | 81 |
| Had health insurance at some point | 19 |
| Don't know | - |
| Refused | - |

[4] Wave 2 question read, "Have you signed up for health insurance that will start in the next couple of months, or not?"

Q1.[‡] What's the MAIN reason you do not currently have health insurance?
(INTERVIEWER NOTE: DO NOT READ LIST. SINGLE RESPONSE ONLY)
(PROBE FOR "MAIN REASON" IF RESPONDENT MENTIONS MORE THAN ONE REASON WHY THEY ARE UNINSURED)

*Based on total uninsured (n=303)*

| | Wave 3 |
|---|---|
| Too expensive/can't afford it | 44 |
| Eligibility Reasons (NET) | 23 |
| Immigration status/not eligible due to immigration status/worries about immigration | 15 |
| Not eligible for medi-Cal, low income health program (LIHP), or government help generally | 7 |
| Not eligible for employer coverage | 1 |
| Don't qualify (general) | * |
| Other qualifying reasons mentions | * |
| Haven't Tried (NET) | 12 |
| Haven't tried/too busy | 6 |
| Don't need/want it | 6 |
| Just haven't done it/haven't tried/haven't applied (general) | * |
| Application Process Related Issues (NET) | 8 |
| Couldn't complete application/technical or enrollment problems | 3 |
| Awaiting contact or approval/unable to contact | 2 |
| Don't know how to get it | 1 |
| Missed deadline to enroll/renew | 1 |
| Lack of information/need more information | * |
| Other application process-related issues mentions | 1 |
| Unavailability (NET) | 4 |
| Plan was cancelled | 3 |
| Employer doesn't offer it | 1 |
| Unemployed/lost job | 4 |
| Opposition | 2 |
| Don't want to be forced to buy anything/prefer to pay penalty | 1 |
| Opposed to the health care law/Obamacare | * |
| Other opposition mentions | * |
| Other Coverage (NET) | 1 |
| Had insurance/medical coverage | * |
| Other "other coverage" mentions | * |
| Other | 2 |
| Don't know | 1 |
| Refused | - |

Q46. As far as you know, does the health care law (INSERT ITEM), or not?
(INTERVIEWER NOTE: If respondent says "Don't Know," do not probe and record answer as "D")
(INTERVIEWER NOTE: REPEAT STEM EACH TIME)

*Based on total uninsured*

| | | Yes, law does this | No, law does not do this | Don't know | Refused |
|---|---|---|---|---|---|
| a. | Require most Americans to have health insurance or else pay a fine | | | | |
| | Wave 3 *(n=282)* | 84 | 12 | 4 | * |
| | Wave 2 *(n=463)* | 81 | 14 | 6 | - |
| | Wave 1[5] *(n=2001)* | 53 | 26 | 20 | * |
| b. | Expand the Medi-Cal program to cover more low-income Californians | | | | |
| | Wave 3 *(n=282)* | 55 | 21 | 24 | * |
| | Wave 2 *(n=463)* | 58 | 27 | 15 | * |
| | Wave 1 *(n=2001)* | 53 | 24 | 23 | - |
| d. | Provide financial help to low and moderate income Americans who don't get insurance through their jobs to help them purchase health insurance coverage | | | | |
| | Wave 3 *(n=282)* | 54 | 30 | 17 | * |
| | Wave 2 *(n=463)* | 60 | 28 | 11 | * |
| | Wave 1[6] *(n=2001)* | 50 | 29 | 21 | - |

B9. Do you think you are PERSONALLY required to have health insurance this year, or does this requirement not apply to you?

*Based on total uninsured*

| | Wave 3 *(n=282)* | Wave 2 *(n=463)* |
|---|---|---|
| Yes, required to have health insurance | 52 | 73 |
| No, requirement does not apply | 43 | 24 |
| Don't know | 5 | 4 |
| Refused | * | * |

[5] Wave 1 item a read, "Require nearly all Americans to have health insurance by 2014 or else pay a fine."
[6] Wave 1 item d read, "Provide financial help to low and moderate income Americans who don't get insurance through their jobs to help them purchase health insurance coverage beginning in 2014"

Q51. As far as you know, are you personally eligible (INSERT ITEMS, SCRAMBLE), or not[7]?
(INTERVIEWER NOTE: If respondent says "Don't Know," do not probe and record answer as "D")

*Based on total uninsured*

| | | Yes, eligible | No, not eligible | Don't know | Refused |
|---|---|---|---|---|---|
| a. | To get insurance through Medi-Cal [INTERVIEWER NOTE: If respondent says they'll get insurance through MediCARE or say they will be eligible for MediCARE when they are 65, please specify that this is Medi-CAL] | | | | |
| | Wave 3 *(n=282)* | 26 | 52 | 21 | 1 |
| | Wave 2 *(n=463)* | 30 | 48 | 22 | - |
| | Wave 1 *(n=2001)* | 43 | 32 | 25 | * |
| c. | To get financial assistance from the government to help pay for health insurance | | | | |
| | Wave 3*(n=282)* | 20 | 59 | 21 | - |
| | Wave 2 *(n=463)* | 26 | 48 | 26 | - |
| | Wave 1 *(n=2001)* | 34 | 39 | 27 | - |

B21.‡ From which of the following sources have you tried to get health insurance since in the past 6 months?[8] What about (INSERT, SCRAMBLE ITEMS A-E, ALWAYS INSERT ITEM C BEFORE ITEM D, ALWAYS INSERT ITEM F LAST)?
[READ IF NECESSARY: Have you tried to get insurance (INSERT) in the past 6 months, or not?]

*Based on total uninsured who tried to get health insurance*

| | | Yes | No | Don't know | Refused |
|---|---|---|---|---|---|
| a. | From Medi-Cal | | | | |
| | Wave 3 *(n=112)* | 53 | 45 | 2 | - |
| | Wave 2 *(n=168)* | 53 | 46 | * | 1 |
| b. | From your or your spouse's or your parents' employer[9] | | | | |
| | Wave 3 *(n=112)* | 20 | 80 | * | - |
| | Wave 2 *(n=168)* | 15 | 85 | * | * |
| c. | Through Covered California, the health insurance marketplace set up under the health care law | | | | |
| | Wave 3 *(n=112)* | 53 | 45 | 2 | - |
| | Wave 2 *(n=168)* | 63 | 34 | 3 | * |
| d. | Directly from a private insurance company, other than through Covered California | | | | |
| | Wave 3 *(n=112)* | 26 | 72 | 2 | - |
| | Wave 2 *(n=168)* | 28 | 69 | 2 | * |
| e. | From a health insurance broker or agent | | | | |
| | Wave 3 *(n=112)* | 29 | 71 | - | - |
| | Wave 2*(n=168)* | 19 | 79 | 2 | * |

[7] Wave 1 question read, "As far as you know, will you personally be eligible (INSERT ITEMS) as a result of the health care law, or not?"
[8] Wave 2 question read, "From which of the following sources have you tried to get health insurance since October 1st?"
[9] Wave 2 item b read, "From your or your spouse's employer."

T5.[‡] Did you not get health insurance (INSERT ITEM, SCRAMBLE ITEMS A-C, ALWAYS INSERT ITEM D LAST), or (PN: FOR ITEMS A-C: was that not a reason/ FOR ITEM D: not)?

*Based on total uninsured who have tried to get health insurance (n=112)*

| | | Wave 3 | | | |
|---|---|---|---|---|---|
| | | Yes, that was a reason | No, that was not a reason | Don't know | Refused |
| a. | Because it was too expensive | 70 | 27 | 3 | - |
| b. | Because you were not able to complete the application process | 25 | 72 | 2 | 1 |
| c. | Because you were told you weren't eligible for coverage | 37 | 61 | 2 | - |
| d. | For some other reason | 4 | 91 | 2 | 3 |

T6. Did you shop for health insurance, or did you not bother because you don't think you can afford it?

*Based on total uninsured who have tried to get health insurance, but could not because it was too expensive (sample size insufficient to report)*

T5a/T6 Combo Table based on total uninsured who tried to get health insurance (n=103)

| | Wave 3 | |
|---|---|---|
| Tried to get health insurance but didn't get it because it was too expensive | 71 | |
| Yes, shopped for health insurance | | 36 |
| No, didn't bother | | 33 |
| Don't know | | 2 |
| Refused | | - |
| Cost was not a reason for not getting health insurance | 26 | |
| Don't know if cost was a reason for not getting health insurance | 3 | |
| Refused | - | |

T7. Did someone help you with the application process, or not?

*Based on total uninsured who have tried to get health insurance, but could not get it because of the application process (sample size insufficient to report)*

T5b/T7 Combo Table based on total uninsured who tried to get health insurance (n=103)

| | Wave 3 | |
|---|---|---|
| Tried to get health insurance but didn't get it because couldn't complete application process | 25 | |
| Yes, someone helped me | | 7 |
| No, no one helped me | | 18 |
| Don't know | | - |
| Refused | | - |
| Application process was not a reason for not getting health insurance | 73 | |
| Don't know if application process was a reason for not getting health insurance | 2 | |
| Refused | - | |

T8. Who told you that you were not eligible?
[IF NECESSARY: "I will be typing this information in, so I would appreciate it if you could speak slowly."]

*Based on total uninsured who have tried to get health insurance, but could not get it because they were told they were not eligible (sample size insufficient to report)*

T5c/T8. Combo Table based on total uninsured who tried to get health insurance (n=103)

| | Wave 3 | |
|---|---|---|
| Tried to get health insurance but didn't get it because told ineligible | 38 | |
| The healthcare exchange/Covered California | | 5 |
| Medi-Cal/low income health program | | 5 |
| Employer | | 7 |
| Social worker | | 18 |
| Other | | 2 |
| Don't know | | - |
| Refused | | - |
| Eligibility was not a reason for not getting health insurance | 60 | |
| Don't know if eligibility was a reason for not getting health insurance | 3 | |
| Refused | - | |

T9. What reason did they give you? (OPEN-END, ACCEPT ONE RESPONSE)
[IF NECESSARY: "I will be typing this information in, so I would appreciate it if you could speak slowly."]

*Based on total uninsured who have tried to get health insurance, but could not because they were told they were not eligible (sample size insufficient to report)*

T5/T9. Combo Table based on total uninsured who tried to get health insurance (n=103)

| | Wave 3 | |
|---|---|---|
| Tried to get health insurance but didn't get it because told ineligible | 38 | |
| Immigration status/not a resident/undocumented | | 9 |
| Income too high | | 6 |
| Income too low/wouldn't be about to afford it | | 8 |
| Other | | 7 |
| They didn't' give me a reason | | 4 |
| Don't know | | 3 |
| Refused | | - |
| Eligibility was not a reason for not getting health insurance | 60 | |
| Don't know if eligibility was a reason for not getting health insurance | 3 | |
| Refused | - | |

Q57a. If you found out you had to pay a fine for not having health insurance last year in 2014, how likely would you be to sign up for coverage this year?

*Based on total uninsured (n=282)*

| | Wave 3 |
|---|---|
| Very likely | 28 |
| Somewhat likely | 27 |
| Not too likely | 11 |
| Not at all likely | 29 |
| Depends on the cost (Vol.) | 4 |
| Had coverage last year (Vol.) | * |
| Don't know | * |
| Refused | * |

B27. Do you think you will have to pay a fine for not having health insurance this year, or not?

*Based on total uninsured*

| | Wave 3 *(n=282)* | Wave 2 *(n=463)* |
|---|---|---|
| Yes | 41 | 44 |
| No | 47 | 43 |
| Don't know | 11 | 13 |
| Refused | 1 | - |

B28. In your experience, how much information about signing up for health insurance is available in Spanish? A lot, some, only a little, or none?

*Based on total uninsured who completed interview in Spanish*

| | Wave 3 *(n=141)* | Wave 2 *(n=191)* |
|---|---|---|
| A lot | 39 | 31 |
| Some | 27 | 22 |
| Only a little | 25 | 31 |
| None | 8 | 8 |
| Don't know | * | 8 |
| Refused | - | - |

B29. As far as you know, are there people in your community trained to help you sign up for health insurance (in Spanish), or not? (INSERT LANGUAGE IN PARENTHESES IF INTERVIEWED IN SPANISH)

*Based on total uninsured*

| | Wave 3 *(n=282)* | Wave 2 *(n=463)* |
|---|---|---|
| Yes | 53 | 44 |
| No | 31 | 44 |
| Don't know | 16 | 12 |
| Refused | - | - |

B10. Since November 15th, have you visited the website for the health insurance marketplace known as Covered California, or not?

*Based on total uninsured*

| | Wave 3 *(n=282)* | Wave 2[10] *(n=463)* |
|---|---|---|
| Yes | 14 | 30 |
| No | 85 | 70 |
| Don't know | * | * |
| Refused | - | - |

[10] Wave 2 question read "Since October 1st, have you visited the website for the health insurance marketplace known as Covered California, or not?"

B11a. How helpful did you find your visit to the Covered California website? Was your visit to the website very helpful, somewhat helpful, not too helpful or not at all helpful?

*Based on total uninsured who visited the website for the health insurance marketplace (sample size insufficient to report)*

B10/B11a. Combo table based on total uninsured

| | Wave 3 *(n=282)* | Wave 2 *(n=463)* |
|---|---|---|
| Visited the website for the health insurance marketplace | 14 | 30 |
| Website was very helpful | 1 | 2 |
| Website was somewhat helpful | 6 | 8 |
| Website was not too helpful | 4 | 11 |
| Website was not at all helpful | 3 | 9 |
| Don't know/Refused | - | - |
| Did not visit the website for the health insurance marketplace | 85 | 70 |
| Don't know | * | * |
| Refused | - | - |

B12. Since November 15th, have you called a 1-800 number for the health insurance marketplace known as Covered California, or not?

*Based on total uninsured*

| | Wave 3 *(n=282)* | Wave 2[11] *(n=463)* |
|---|---|---|
| Yes | 7 | 15 |
| No | 93 | 85 |
| Don't know | * | * |
| Refused | - | - |

B13. How helpful did you find your call to Covered California? Was the call very helpful, somewhat helpful, not too helpful or not at all helpful?

*Based on total uninsured who called a 1-800 number for the health insurance marketplace (sample size insufficient to report)*

B12/B13. Combo table based on total uninsured

| | Wave 3 *(n=282)* | Wave 2 *(n=463)* |
|---|---|---|
| Called a 1-800 number for the health insurance marketplace | 7 | 15 |
| Call was very helpful | 1 | 1 |
| Call was somewhat helpful | 3 | 4 |
| Call was not too helpful | 1 | 3 |
| Call was not at all helpful | 2 | 6 |
| Don't know/Refused | - | * |
| Did not call a 1-800 number for the health insurance marketplace | 93 | 85 |
| Don't know | * | * |
| Refused | - | - |

[11] Wave 2 question read "Since October 1st, have you called a 1-800 number for the health insurance marketplace known as Covered California, or not?"

B30. ‡ What is the MAIN reason you decided to get health insurance? (OPEN-ENDED) [12]

*Based on total insured*

| | Wave 3 *(n=797)* | Wave 2 *(n=740)* |
|---|---|---|
| Health-Related (NET) | 42 | 46 |
| Preventive/Planning Ahead (SUBNET) | 27 | 16 |
| Need it in case I get sick/injured | 18 | 12 |
| Preventative care/staying healthy | 9 | 4 |
| Other preventative/planning ahead mentions | * | - |
| Other health-related mentions | * | 1 |
| Health Problems/Preexisting Conditions (SUBNET) | 13 | 17 |
| Health problem/pre-existing condition | 12 | 17 |
| Pregnant/had baby | 1 | - |
| Other health problems/preexisting conditions mentions | * | 1 |
| General Health Reasons (SUBNET) | 3 | 8 |
| For checkups/doctor's visits (general) | 1 | 4 |
| For my/my family's health (general) | 1 | 4 |
| It's the law/don't want to be fined | 26 | 21 |
| Insurance Option Became Available (NET) | 13 | 17 |
| Got it through employer | 6 | 7 |
| Eligible for medical/financial help | 3 | 3 |
| Obtained it through health exchange/ACA | 1 | - |
| Insurance became affordable/now I can afford it/became free | 1 | 1 |
| Other insurance option became available mentions | 1 | 2 |
| Obtained it through the military/veteran's administration | * | 1 |
| Insurance became available/offered (nonspecific) | * | 2 |
| Importance Of Health Insurance In General (NET) | 4 | 5 |
| Everyone should have it | 3 | 2 |
| It's too expensive if you don't have it (will have big bills/go bankrupt/etc.) | * | 2 |
| Other importance of health insurance in general mentions | * | 1 |
| Wanted it/Needed it | 9 | 5 |
| Because of my Age/am getting older/old | 3 | 4 |
| Had insurance previously | 1 | 2 |
| Other | 1 | 4 |
| Don't know | * | - |
| Refused | * | * |

[12] Question in Wave 3 included pre-listed response codes.

B32. ‡ Which of the following is your MAIN source of health insurance coverage? Is it a plan through your or your spouse's employer, (a plan through a parent), a plan you purchased yourself either from an insurance company or Covered California, are you covered by Medi-Cal, (or Medicare), or do you get your health insurance from somewhere else?

[ONLY SHOW IF B19a=1 or U1=3 "SIGNED UP FOR COVERAGE THAT STARTS IN NEXT COUPLE MONTHS": IF NECESSARY: I'm asking about the plan that you signed up for that will begin covering you in the next month.] (INTERVIEWER NOTE: If R says they got insurance through Healthcare.gov, Obamacare, or Covered California, CODE AS 3; If R says they have both MediCAID/Medi-CAL and MediCARE code as CODE AS 4, "Medi-Cal")

*Based on total insured*

| | Wave 3 *(n=797)* | Wave 2 *(n=740)* |
|---|---|---|
| Plan through your/your spouse's employer | 21 | 19 |
| (INSERT IF 19-25 YEARS OLD) Plan through your parents/mother/father | 3 | 5 |
| Plan you or your spouse purchased yourself, either from an insurance company or Covered California | 20 | 22 |
| Medi-Cal | 50 | 44 |
| Somewhere else | 4 | 7 |
| (INSERT IF 65 YEARS OLD) Medicare | 3 | 1 |
| Don't know | * | 1 |
| Refused | * | * |

B32A. ‡ Do you also have Medi-CAL coverage, or only Medicare coverage?

*Based on total insured whose main source of health insurance coverage is Medicare (sample size insufficient to report)*

B33. ‡ Do you happen to know if your parent's plan is through an employer or a plan they purchased themselves either from an insurance company or Covered California?

*Based on total insured whose main source of health insurance coverage is a plan through parents (sample size insufficient to report)*

B34. ‡ Did you purchase your plan directly from an insurance company, directly from the marketplace known as Covered California, or through a health insurance agent or broker?

*Based total insured whose main source of health insurance coverage is a plan purchased by themselves*

| | Wave 3 *(n=167)* | Wave 2 *(n=153)* |
|---|---|---|
| Directly from an insurance company | 10 | 11 |
| Directly from Covered California | 67 | 58 |
| Through an agent or broker | 20 | 21 |
| Association (Vol.) | 1 | 1 |
| Don't know | 2 | 4 |
| Refused | * | 5 |

T32. ‡ Regardless of how you purchased your plan, do you know if it is a Covered California plan, is it NOT a Covered California plan, or are you not sure? (ENTER ONE ONLY)

*Based on total insured who purchased their own plan through a means other than Covered California (sample size insufficient to report)*

B36.‡ Do you happen to know if the plan was purchased directly from an insurance company, or from the marketplace known as Covered California?
[INTERVIEWER NOTE: IF R SAYS IT WAS PURCHASED INSURANCE THROUGH A BROKER, ASK "Do you know if that was a plan from the marketplace known as Covered California, or was it a plan purchased directly from an insurance company and not through the marketplace?"]

*Based on total insured whose main source of health insurance coverage is a plan through parents that they purchased themselves (sample size insufficient to report)*

B32/B33/B34/T32/B36‡ Combo table based on total insured[13]

| | Wave 3 (n=797) | Wave 2 (n=1219) |
|---|---|---|
| Plan through your/your spouse/parent's employer | 21 | 21 |
| Self purchased plan | 20 | 25 |
| Purchased directly from an insurance company | 1 | 5 |
| Purchased form Covered California | 18 | 16 |
| Purchased through an association (Vol.) | * | * |
| Don't know/Refused | 1 | 3 |
| Medi-Cal | 50 | 44 |
| Somewhere else | 4 | 8 |
| (INSERT IF 65 YEARS OLD) Medicare | 3 | 1 |
| Don't know | * | 1 |
| Refused | * | * |

Ins/B32/B33/B34/T32/B36‡ Combo table based on total

| | Wave 3 (n=1105) | Wave 2 (n=740) |
|---|---|---|
| Covered by health insurance | 68 | 58 |
| Plan through you/your spouse/parent's employer | 14 | 12 |
| Self-purchased plan | 14 | 14 |
| Purchased directly from an insurance company | 1 | 3 |
| Purchased from Covered California | 12 | 9 |
| Purchased through an association (Vol.) | * | * |
| Don't know/refused | 1 | 2 |
| Medi-Cal | 34 | 25 |
| (INSERT IF 65 YEARS OLD) Medicare | 2 | 1 |
| Somewhere else | 3 | 4 |
| Don't know | * | 1 |
| Refused | * | * |
| Not covered by health insurance | 32 | 42 |
| Don't know | * | - |
| Refused | - | * |

[13] Question T32 was not asked in Wave 2. Wave 2 question read, "Do you know if the plan you purchased through a broker was a plan from the marketplace known as Covered California, or was it a plan purchased directly from an insurance company and not through the marketplace?" and was asked of the newly insured, covered by a plan they purchased themselves through an agent or broker.

B37. ‡ To the best of your knowledge, is your current plan a bronze, silver, gold or platinum plan?

*Based on total whose main source of health insurance coverage is a plan purchased themselves or a plan through parents that they purchased themselves*

| | Wave 3 *(n=168)* | Wave 2[14] *(n=138)* |
|---|---|---|
| Bronze | 25 | 18 |
| Silver | 42 | 45 |
| Gold | 4 | 3 |
| Platinum | 2 | 5 |
| Catastrophic (Vol.) | - | - |
| None of these (Vol.) | 2 | 5 |
| Don't know | 25 | 24 |
| Refused | * | - |

B38. ‡ Is the coverage you have just for yourself or does it also cover other family members?

*Based on total insured*

| | Wave 3 *(n=797)* | Wave 2 *(n=740)* |
|---|---|---|
| Just yourself | 55 | 54 |
| Includes coverage for other family members | 45 | 45 |
| Don't know | - | * |
| Refused | * | * |

(READ IF PURCHASED INSURANCE THAT WILL START IN THE NEXT COUPLE MONTS [B19a=1 or U1=3]): The next set of questions are about your health insurance coverage. For these questions, please think about the plan that you have signed up for that will begin to cover you in the next month. If you feel you are unable to answer any of these questions, just let me know and we'll move on to the next one.

B45. Overall, would you say your experiences with your current health insurance plan have been very positive, somewhat positive, somewhat negative, or very negative?

*Based on total insured*

| | Wave 3 *(n=731)* | Wave 2 *(n=704)* |
|---|---|---|
| Very positive | 32 | 38 |
| Somewhat positive | 44 | 37 |
| Somewhat negative | 12 | 7 |
| Very negative | 6 | 3 |
| Haven't used my plan yet (Vol.) | 6 | 14 |
| Don't know | * | 1 |
| Refused | * | * |

[14] Wave 2 question read, "To the best of your knowledge, did you buy a bronze, silver, gold or platinum plan?"

T10. When you applied to Medi-Cal, how long did it take for you to find out whether or not you were eligible? (READ LIST)

*Based on those covered by Medi-Cal or tried to enroll in Medi-Cal (n=431)*

| | Wave 3 |
|---|---|
| One week or less | 25 |
| More than one week but less than one month | 33 |
| 1 to 2 months | 19 |
| More than 2 months | 19 |
| Don't know | 3 |
| Refused | 1 |

B39. Did your health insurance plan cost (more) than you thought it would or (less) than you thought it would, or was the cost about what you expected? (ROTATE RESPONSES 1-2/2-1)

*Based on total insured*

| | Wave 3 *(n=731)* | Wave 2 *(n=704)* |
|---|---|---|
| More | 19 | 17 |
| Less | 26 | 26 |
| About what you expected | 49 | 43 |
| Don't know | 5 | 14 |
| Refused | 1 | * |

B40. ‡ As far as you know, are you personally getting financial assistance from the government, such as a premium tax credit or premium assistance, to help pay for your health insurance, or not?

*Based on total whose main source of health insurance coverage is a plan purchased from Covered California*

| | Wave 3 *(n=187)* | Wave 2 *(n=116)* |
|---|---|---|
| Yes, getting financial assistance | 51 | 55 |
| No, not getting financial assistance | 43 | 38 |
| Don't know | 6 | 6 |
| Refused | - | - |

T12. ‡ As far as you know, is the amount you pay for your health plan based on your income, or is it not based on your income?

*Based on total insured who say they are not getting financial assistance or don't know or refused to say if they are getting financial assistance (sample size insufficient to report)*

B41. ‡ Do you think you would have been able to afford to buy health insurance without this financial assistance, or not?

*Based on total insured whose main source of health insurance coverage is a plan purchased from Covered California and who is getting financial assistance to pay for health insurance or premium varies by income (n=136)*

| | Wave 3 |
|---|---|
| Yes | 8 |
| No | 88 |
| Don't know | 1 |
| Refused | 3 |

B40/T12/B41[‡] Combo table based on those who say they purchased their plan from Covered California.

| | Wave 3 (n=147) |
|---|---|
| Yes, getting financial assistance/Premium amount based on income | 91 |
| Yes, could afford health insurance without assistance | 7 |
| No, would not have been able to afford health insurance without financial assistance | 80 |
| Don't know/Refused if been able to afford | 3 |
| No, not getting financial assistance/Premium amount based on income | 9 |
| Don't know | 1 |
| Refused | - |

T13. Have you received a form, known as form 1095-A or the Health Insurance Marketplace Statement, from Covered California that contains information about your health insurance coverage needed to file your 2014 taxes, have you not received this form, or are you not sure?

*Based on total with insurance from Covered California in Wave 2 or Wave 3 (n=174)*

| | Wave 3 |
|---|---|
| Yes, received form | 38 |
| No, have not received form | 35 |
| Not sure | 25 |
| Don't know | 2 |
| Refused | - |

T13a. Did this form show that you received a premium tax credit or that the government paid a portion of your health insurance costs in 2014, or not?

*Based on total who received form (sample size insufficient to report)*

T13/T13a Combo table based on *total with insurance from Covered California in Wave 2 or Wave 3 (n=174)*

| | Wave 3 |
|---|---|
| Yes, received form | 38 |
| Yes, form showed respondent received tax credit | 27 |
| No, form did not show respondent received tax credit | 5 |
| Don't know if form showed respondent received tax credit | 6 |
| Refused if form showed respondent received tax credit | - |
| No, have not received form | 35 |
| Not sure | 25 |
| Don't know | 2 |
| Refused | - |

T14. Thinking about the past 12 months, (did you have health insurance the entire time), or (was there some point in the past 12 months when you did NOT have health insurance)? (ROTATE ITEMS IN PARENS)

*Based on total insured (n=731)*

| | Wave 3 |
|---|---|
| Had health insurance the entire time | 58 |
| Did NOT have health insurance at some point during the past 12 months | 42 |
| Don't know | * |
| Refused | * |

T15. ‡ Do you have the same health insurance plan you had last year in 2014, or did you change to a different plan?

*Based on total insured (n=797)*

| | Wave 3 |
|---|---|
| Same plan | 63 |
| Changed to a different plan | 17 |
| No plan last year/uninsured in 2014 (Vol.) | 20 |
| Don't know | * |
| Refused | - |

T16. How easy or difficult was it for you to change to a different health insurance plan? Was it very easy, somewhat easy, somewhat difficult, or very difficult?

*Based on total insured who changed insurance plans (n=128)*

| | Wave 3 |
|---|---|
| Very easy | 37 |
| Somewhat easy | 38 |
| Somewhat difficult | 17 |
| Very difficult | 7 |
| Don't know | 1 |
| Refused | * |

T17. I'm going to read you some reasons people give for changing health plans. For each, please tell me if this is a reason why you switched to a different health plan this year or not. (First/next), (READ ITEM, SCRAMBLE).
(READ FOR 1st ITEM, THEN AS NECESSARY: "Is this a reason why you changed health plans, or not?")

*Based on total insured who changed plans (n=128)*

| | Wave 3 | | | |
|---|---|---|---|---|
| | Yes, reason | No, not a reason | Don't know | Refused |
| a. Your income changed | 47 | 52 | 1 | - |
| b. You wanted to be eligible for government financial help *(Based on those insured by Covered California – sample size insufficient to report)* | | | | |
| c. You or your family's health needs changed | 28 | 71 | 1 | - |
| d. You wanted a plan with more choice of providers or one that covered a specific provider | 43 | 57 | - | - |
| e. You found a plan with a lower monthly premium than what you would have paid to renew your previous plan (*Based on those insured through a plan other than Medi-Cal – sample size insufficient to report)* | | | | |
| f. You wanted a plan with a lower annual deductible (*Based on those insured through a plan other than Medi-Cal – sample size insufficient to report)* | | | | |
| g. You were able to enroll in a plan through an employer (*Based on those insured through an employer – sample size insufficient to report)* | | | | |

T15/T17a-g Combo tabled based on those who are insured *(n=731)*

| | Wave 3 |
|---|---|
| Kept same insurance plan | 62 |
| Changed to a different plan | 17 |
| a. Your income changed | 8 |
| b. You wanted to be eligible for government financial help | 1 |
| c. You or your family's health needs changed | 5 |
| d. You wanted a plan with more choice of providers or one that covered a specific provider | 7 |
| e. You found a plan with a lower monthly premium than what you would have paid to renew your previous plan | 3 |
| f. You wanted a plan with a lower annual deductible | 3 |
| g. You were able to enroll in a plan through an employer | 3 |
| No plan last year/ uninsured in 2014 | 21 |
| Don't know | * |
| Refused | - |

*Numbers add up to more than 17% because multiple responses were accepted*

T19. Did you take action to re-enroll in the same health plan, or were you re-enrolled without having to take any action?

*Based on total insured who kept their plan (n=480)*

| | Wave 3 |
|---|---|
| Took action to re-enroll in same plan | 35 |
| Were re-enrolled without having to take any action | 62 |
| Don't know | 2 |
| Refused | * |

T20. When you renewed your health plan this year, did you shop around or look at other options first, or did you decide to renew your current plan without shopping around?

*Based on total insured who kept their plan (n=480)*

| | Wave 3 |
|---|---|
| Shopped around | 12 |
| Did not shop around | 87 |
| Don't know | 1 |
| Refused | 1 |

T21. How easy or difficult was it for you to renew your health plan? Was it very easy, somewhat easy, somewhat difficult, or very difficult?

*Based on total insured who kept their plan (n=480)*

| | Wave 3 |
|---|---|
| Very easy | 58 |
| Somewhat easy | 26 |
| Somewhat difficult | 11 |
| Very difficult | 3 |
| Don't know | 2 |
| Refused | * |

T22. Did you receive information from the insurance company, Covered California or Medi-Cal about how to keep your 2014 coverage this year, or not?

*Based on total insured who kept their plan (n=480)*

| | Wave 3 |
|---|---|
| Received information | 59 |
| Did not receive any information | 37 |
| No plan last year/ uninsured in 2014 (Vol.) | 1 |
| Don't know | 3 |
| Refused | - |

B42. Did you (purchase/sign up for) your current plan on the phone, in-person, on the internet, or some other way?[15] [INTERVIEWER NOTE: If RESPONDENT SAYS MORE THAN ONE, ASK: What were you using when you finished the process?]

*Based on total insured whose main source of health insurance is not a plan through employer*

| | Wave 3 *(n=606)* | Wave 2 *(n=587)* |
|---|---|---|
| Phone | 23 | 19 |
| In Person | 33 | 38 |
| On the Internet | 21 | 23 |
| By mail (Vol.) | 10 | 6 |
| Someone else (family member/friend) took care of it for me (Vol.) | 1 | 3 |
| Some other way | 11 | 9 |
| Don't know | * | 1 |
| Refused | - | * |

B43. Did someone help you (enroll in health insurance/renew your health plan) or did you complete the (enrollment/renewal) process on your own?

*Based on total insured whose main source of health insurance is not a plan through employer*

| | Wave 3 *(n=606)* | Wave 2 *(n=587)* |
|---|---|---|
| Someone helped me | 42 | 59 |
| Completed it alone | 47 | 37 |
| Someone did the whole thing for me (Vol.) | 2 | 4 |
| Automatically renewed (Vol.) | 8 | - |
| Don't know | 1 | * |
| Refused | - | - |

B44. Who was that person? Was it a family member or friend, a Covered California representative, a health insurance broker or agent, a community or county health worker, a health plan representative, or someone else?

*Based on total insured whose main source of health insurance is not a plan through employer and had help enrolling in health insurance*

| | Wave 3 *(n=270)* | Wave 2[16] *(n=338)* |
|---|---|---|
| Family member or friend | 16 | 26 |
| A Covered California representative | 31 | 16 |
| A health insurance broker or agent | 11 | 14 |
| A community or county health worker | 25 | 33 |
| A health plan representative | 6 | |
| Someone else | 9 | 10 |
| Don't know | 2 | 1 |
| Refused | - | - |

*Numbers may add up to more than 100% because multiple responses were accepted*

[15] Wave 2 question read "Did you (purchase/sign up for) your plan on the phone, in-person, on the internet, or some other way?"

[16] Wave 2 question read, "Who was that person? Was it a family member or friend, a Covered California representative, a health insurance broker or agent, a community or county health worker, or someone else?"

B43/B44. Combo table based on total insured whose main source of health insurance coverage is not a plan through employer

| | Wave 3 (n=606) | Wave 2 (n=587) |
|---|---|---|
| Someone helped/did the whole thing for me (NET) | 44 | 63 |
| Family member or friend | 7 | 16 |
| A Covered California representative | 14 | 10 |
| A health insurance broker or agent | 5 | 9 |
| A community or county health worker | 11 | 21 |
| A health plan representative | 3 | |
| Someone else | 4 | 6 |
| Don't know/Refused | 1 | 1 |
| Completed it alone | 47 | 37 |
| Automatically renewed (Vol.) | 8 | - |
| Don't know | 1 | * |
| Refused | - | - |

*Numbers may add up to more than 100% because multiple responses were accepted*

B50. How easy or difficult was it for you to (INSERT)? Very easy, somewhat easy, somewhat difficult, very difficult?

| | Very easy | Somewhat easy | Somewhat difficult | Very difficult | Did not Attempt (Vol.) | Did not try to find Someone (Vol.) | Don't know | Refused | Not Asked |
|---|---|---|---|---|---|---|---|---|---|
| c. Figure out if your income qualifies you for Medi-Cal *[asked of total insured through Medi-Cal or tried to get health insurance through Medi-Cal]* | | | | | | | | | |
| Wave 3 *(n=431)* | 39 | 33 | 18 | 7 | * | - | 2 | 1 | - |
| Wave 2 *(n=428)* | 45 | 22 | 17 | 14 | * | - | 1 | - | 1 |
| d. Figure out if your income qualifies you for financial assistance *[asked of total insured through Covered California or tried to get health insurance through Covered California]* | | | | | | | | | |
| Wave 3 *(n=197)* | 37 | 23 | 24 | 11 | 3 | - | 2 | - | - |
| Wave 2 *(n=208)* | 22 | 28 | 24 | 16 | 2 | - | 6 | 2 | - |
| f. Compare the services that would be covered by the plans *[asked of total who have coverage through a plan purchased themselves directly from an insurer or through Covered California]* | | | | | | | | | |
| Wave 3 *(n=151)* | 30 | 35 | 26 | 7 | 2 | - | * | * | - |
| Wave 2 *(n=255)*[17] | 21 | 20 | 32 | 22 | 4 | - | 2 | - | - |
| g. Compare the amount you would have to pay to use health services *[asked of total who have coverage through a plan purchased themselves directly from an insurer or through Covered California]* | | | | | | | | | |
| Wave 3 *(n=151)* | 30 | 34 | 17 | 8 | 5 | - | 6 | * | - |
| Wave 2 *(n=255)*[18] | 20 | 27 | 25 | 21 | 5 | - | 2 | - | - |

[17] Wave 2 item f was asked of newly insured who have coverage through a plan purchased themselves directly from an insurer or through Covered California or those who tried to get coverage through these sources.

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| h. Compare the monthly amount you would have to pay for coverage *[asked of total who have coverage through a plan purchased themselves directly from an insurer or through Covered California]* | | | | | | | | | |
| Wave 3 *(n=151)* | 39 | 35 | 12 | 7 | 6 | - | 2 | - | - |
| Wave 2 *(n=255)*[19] | 27 | 24 | 23 | 22 | 4 | - | 1 | - | - |
| i. Find someone to help you enroll or answer your questions *[asked of total insured other than through an employer]* | | | | | | | | | |
| Wave 3 *(n=612)* | 41 | 33 | 12 | 10 | 2 | 2 | * | * | - |
| Wave 2 *(n=587)* | 45 | 27 | 11 | 13 | 3 | 2 | * | - | - |
| j. Get confirmation from (the county/Covered California) that your coverage has started *[asked of total insured through Medi-Cal or Covered California]* | | | | | | | | | |
| Wave 3 (*n=518)* | 41 | 32 | 13 | 10 | 1 | - | 2 | 2 | - |
| Wave 2 *(n=454)* | 38 | 23 | 17 | 16 | 1 | - | 4 | - | * |

B52. Does having health insurance make you feel (more) financially secure, (less) financially secure, or did it make no difference in how financially secure you feel? (ROTATE RESPONSES IN PARENS)

*Based on total insured*

| | Wave 3 *(n=731)* | Wave 2[20] *(n=704)* |
|---|---|---|
| More financially secure | 53 | 37 |
| Less financially secure | 10 | 16 |
| No difference | 36 | 45 |
| Don't know | * | 1 |
| Refused | * | * |

B53. In general, do you feel well-protected by your health insurance plan, or do you feel vulnerable to high medical bills?

*Based on total insured*

| | Wave 3 *(n=731)* | Wave 2 *(n=704)* |
|---|---|---|
| Well-protected | 62 | 64 |
| Vulnerable to high medical bills | 33 | 30 |
| Just got my plan/ too soon to tell (Vol.) | 3 | - |
| Don't know | 2 | 5 |
| Refused | * | * |

[18] Wave 2 item g was asked of newly insured who have coverage through a plan purchased themselves directly from an insurer or through Covered California or those who tried to get coverage through these sources.

[19] Wave2 item h was asked of asked of newly insured who have coverage through a plan purchased themselves directly from an insurer or through Covered California or those who tried to get coverage through these sources.

[20] Wave 2 question read, "Did gaining health insurance make you feel (more) financially secure, (less) financially secure, or did it make no difference in how financially secure you feel?"

B54. How difficult is it for you to afford to pay the cost of health insurance each month? Is it very, somewhat, not too or not at all difficult for you to pay for health insurance?

*Based on total insured whose main source of health insurance coverage is not Medi-Cal*

| | Wave 3 *(n=339)* | Wave 2 *(n=355)* |
|---|---|---|
| Very difficult | 13 | 16 |
| Somewhat difficult | 41 | 30 |
| Not too difficult | 20 | 25 |
| Not at all difficult | 22 | 25 |
| Haven't paid yet (Vol.) | 4 | 1 |
| Don't know | * | 2 |
| Refused | * | - |

B55. How well do you feel you understand what healthcare services your plan covers and what it doesn't? Would you say you understand it very well, somewhat well, not too well, or not well at all?

*Based on total insured*

| | Wave 3 *(n=731)* | Wave 2 *(n=704)* |
|---|---|---|
| Very well | 31 | 31 |
| Somewhat well | 33 | 39 |
| Not too well | 27 | 19 |
| Not at all well | 8 | 10 |
| Don't know | * | 2 |
| Refused | 1 | * |

B56. How well do you feel you understand how much you would have to pay when you visit a doctor or health care provider? Would you say you understand it very well, somewhat well, not too well, or not well at all?

*Based on total insured*

| | Wave 3 *(n=731)* | Wave 2 *(n=704)* |
|---|---|---|
| Very well | 40 | 45 |
| Somewhat well | 32 | 29 |
| Not too well | 19 | 16 |
| Not at all well | 8 | 8 |
| Don't know | 1 | 2 |
| Refused | 1 | * |

T29. Thinking about your current health insurance plan, how satisfied are you with each of the following? What about (INSERT, SCRAMBLE)?
(READ 1st TIME, THEN AS NECESSARY: Are you very satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied?)

*Based on total insured (n=731)*

| | | Wave 3 | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | Very satisfied | Somewhat satisfied | Somewhat dissatisfied | Very dissatisfied | Just got my plan/ too soon to tell (Vol.) | Don't know | Refused |
| a. | The choice of primary care doctors available under your plan | 39 | 40 | 7 | 8 | 3 | 1 | 1 |
| b. | The choice of hospitals available under your plan | 38 | 37 | 9 | 5 | 7 | 3 | * |
| c. | The choice of specialists, such as cardiologists and orthopedists, available under your plan | 30 | 37 | 10 | 5 | 13 | 5 | 1 |

T23. In the past twelve months, were you told by a doctor's office or clinic that they would not accept you as a new patient, or not?

| | Wave 3 |
|---|---|
| Yes | 13 |
| No | 83 |
| Haven't tried to become a new patient (Vol.) | 4 |
| Don't know | * |
| Refused | - |

T24. In the past twelve months, have you had to wait longer than you thought was reasonable to get an appointment for medical care, or not?

| | Wave 3 |
|---|---|
| Yes | 25 |
| No | 69 |
| Haven't tried to get an appointment (Vol.) | 6 |
| Don't know | * |
| Refused | - |

Q42. In the past 12 months, did you have any problems paying medical bills, or not?

| | Wave 3 | Wave 1 |
|---|---|---|
| Yes | 24 | 40 |
| No | 75 | 60 |
| Don't know | 1 | * |
| Refused | - | - |

Q43. How much of a financial impact have these medical bills had on your household – a major impact, minor impact or no impact at all?

*Based on total who had problems paying medical bills*

| | Wave 3 *(n=222)* | Wave 1 *(n=776)* |
|---|---|---|
| Major impact | 57 | 57 |
| Minor impact | 37 | 33 |
| No impact at all | 6 | 9 |
| Don't know | - | * |
| Refused | - | * |

Q42/Q43 Combo table based on total

| | Wave 3 | Wave 1 |
|---|---|---|
| Had problems paying medical bills | 24 | 40 |
| Medical bills had a major impact | 14 | 22 |
| Medical bills had a minor impact | 9 | 13 |
| Medical bills had no impact at all | 2 | 4 |
| Don't know/refused impact | - | - |
| Did not have problems paying medical bills | 75 | 60 |
| Don't know | 1 | * |
| Refused | - | - |

T76. Was there a time over the past twelve months when you needed medical care, but did not get it because of the cost, or not?

| | Wave 3 |
|---|---|
| Yes, there was | 27 |
| No, there was not | 73 |
| Don't know | * |
| Refused | * |

(READ:) One another topic…

T25. Did your monthly income increase or decrease at any point in 2014, or was your income pretty much the same each month in 2014?
(INTERVIEWER NOTE: If R says income is different every month, code as increase/decrease and ask follow-up)
(IF INCREASED OR DECREASED: Was that a big change or just a small change?)

| | Wave 3 |
|---|---|
| Change In Income (NET) | 38 |
| Big change in monthly income | 19 |
| Small change in monthly income | 19 |
| Income was pretty much the same each month | 62 |
| Don't know | * |
| Refused | * |

T26. Did you let Covered California or Medi-Cal know about changes to your income in 2014, or not?

*Based on total who had an income change and were insured in Wave 2 and Wave 3 by Covered California or Medi-Cal in either wave (n=216)*

| | Wave 3 |
|---|---|
| Yes | 49 |
| No | 41 |
| Didn't have coverage from Cov CA/Medi-Cal last year (Vol.) | 8 |
| Don't know | 1 |
| Refused | 2 |

T27. As far as you know, when someone gets financial help from the government to pay their health insurance premium, is it possible they would end up owing money to the government if their income or family size changes during the year, or not?

| | Wave 3 |
|---|---|
| Yes | 49 |
| No | 26 |
| Don't know | 24 |
| Refused | * |

B63. How worried, if at all, are you that if you sign up for health insurance you will draw attention to your or a family member's immigration status? Are you very worried, somewhat worried, not too worried, or not at all worried? [IF NEEDED: Our questions are for research purposes only and your answers are strictly confidential.]

*Based on total uninsured*

| | Wave 3 *(n=282)* | Wave 2 *(n=463)* |
|---|---|---|
| Very worried | 23 | 26 |
| Somewhat worried | 15 | 12 |
| Not too worried | 11 | 7 |
| Not at all worried | 51 | 55 |
| Don't know | - | 1 |
| Refused | * | - |

B64. Are you worried that you or a family member could be deported if you sign up for health insurance, or not? [IF NEEDED: Our questions are for research purposes only and your answers are strictly confidential.]

*Based on total uninsured who worried about drawing attention to immigration status (sample size insufficient to report)*

B63/B64. Combo table based on total uninsured

| | Wave 3 *(n=282)* | Wave 2 *(n=463)* |
|---|---|---|
| Worried about drawing attention to immigration status (NET) | 38 | 37 |
| Yes, worried could be deported | 29 | 23 |
| No, not worried could be deported | 9 | 13 |
| Don't know/Refused if worried | * | 1 |
| Not worried about drawing attention to immigration status | 62 | 62 |
| Don't know | - | 1 |
| Refused | * | - |

B65. How worried, if at all, are you that signing up for health insurance could hurt your ability to become a U.S. citizen? Are you very worried, somewhat worried, not too worried, or not at all worried?
[IF NEEDED: Our questions are for research purposes only and your answers are strictly confidential.]

*Based on total uninsured who were born in another country*

| | Wave 3 *(n=165)* | Wave 2 *(n=231)* |
|---|---|---|
| Very worried | 35 | 46 |
| Somewhat worried | 20 | 19 |
| Not too worried | 17 | 6 |
| Not at all worried | 23 | 22 |
| I am a US citizen (Vol.) | 5 | 5 |
| Don't know | * | 2 |
| Refused | * | - |

(READ ALL) And just to update this information…

D2. ‡ Are you currently married, living with a partner, widowed, divorced, separated, or have you never been married?

| | Wave 3 |
|---|---|
| Married | 37 |
| Not Married (NET) | 62 |
| Living with a partner | 12 |
| Widowed | 2 |
| Divorced | 7 |
| Separated | 4 |
| Never been married | 37 |
| Don't know | * |
| Refused | * |

Q37. ‡ How many dependent children do you have, if any?
[INTERVIEWER NOTE: If respondent asks to clarify what "dependent children" means, say "Any child who is dependent on you for support, or who you claim as a dependent on your tax return"]

| | Wave 3 |
|---|---|
| None | 52 |
| One | 16 |
| Two | 17 |
| Three | 9 |
| Four | 3 |
| Five | 1 |
| Six – Ten | * |
| Eleven – Fifteen | - |
| Don't know | - |
| Refused | * |

D3. ‡ What best describes your employment situation today?
(READ LIST IN ORDER)
(INTERVIEWER NOTE: If respondent asks to define "full-time" please define as 30 or more hours per week)

| | Wave 3 |
|---|---|
| Employed (NET) | 62 |
| Employed full-time | 38 |
| Employed part-time | 24 |
| Not Employed (NET) | 38 |
| Unemployed and currently seeking employment | 13 |
| Unemployed and not seeking employment | 2 |
| A student | 5 |
| Retired | 2 |
| On disability and can't work | 5 |
| A homemaker or stay at home parent | 12 |
| Don't know | * |
| Refused | * |

Q65. ‡ In general, would you say your health is excellent, very good, good, fair, or poor?

| | Wave 3 |
|---|---|
| Excellent | 13 |
| Very good | 22 |
| Good | 29 |
| Fair | 30 |
| Poor | 6 |
| Don't know | * |
| Refused | * |

D14. ‡ Besides yourself, how many people are in your family, meaning your spouse and any dependent children?
[INTERVIEWER NOTE: If respondent asks to clarify what "dependent children" means, say "Any child who is dependent on you for support, or who you claim as a dependent on your tax return"]

*Based on total who answered "Don't know" to marital status and number of children (sample size insufficient to report)*

D17. ‡ Does anyone else, such as a parent, claim you as a dependent on their tax return?

*Based on total who are not married, are without children, unemployed and under 30 years old (sample size insufficient to report)*

D18. ‡ Is the parent who claims you as a dependent married, or not?
(INTERVIEWER NOTE: If R says their parents are married but not to each other, code as "1: Married")
(INTERVIEWER NOTE: If the R is not claimed by their parent, ask about the person claiming them as a dependent)

*Based on total who are claimed as a dependent (sample size insufficient to report)*

D19.‡ Besides yourself, how many other dependent children (do/does) your (parents/parent) have?
(INTERVIEWER NOTE: If the R is not claimed by their parent, ask about the person claiming them as a dependent)

*Based on total who are claimed as a dependent (sample size insufficient to report)*

**FAMILYSIZE**

| | Wave 3 |
|---|---|
| One | 39 |
| Two | 21 |
| Three | 14 |
| Four | 14 |
| Five + | 12 |

**FEDERAL POVERTY LINE**

D15.‡ To help us describe the people who took part in our study, it would be helpful to know which category best describes your (personal/family) income last year before taxes.
[Family income only includes income from you yourself, (AND your spouse), (and your dependent children) (AND your spouse and/or any dependent children), (AND your {parents/parent}), (AND any other dependent children of your {parents/parent}), (AND/OR any other dependent children of your {parents/parent})].
Is your total annual (personal/family) income from all sources, and before taxes, less than (AMOUNT 1), at least (AMOUNT 1) but less than (AMOUNT 3) or (AMOUNT 3) or more?
[INTERVIEWER: IF RESPONDENT REFUSES: Your responses are strictly confidential and are not attached to any identifying information. It is important for us to know this information to help us describe people who took part in our study.]
[INTERVIEWER: IF RESPONDENT SAYS THEY ARE NOT SURE, PROBE: Can you estimate?]

D.15A.‡ Is that less than (AMOUNT 2) or (AMOUNT 2) or more?

(INTERVIEWER NOTE: PLEASE READ NUMBER AMOUNTS SLOWLY AND CAREFULLY)

D16.‡ How about average monthly income? Can you estimate whether your (personal/family's) average **monthly** income from all sources was less than (AMOUNT 1 M*), at least (AMOUNT 1 M*) but less than (AMOUNT 3 M*) or (AMOUNT 3 M*) or more?
[Family income only includes income from you yourself, (AND your spouse), (and your dependent children) (AND your spouse and/or any dependent children), (AND your {parents/parent}), (AND any other dependent children of your {parents/parent}), (AND/OR any other dependent children of your {parents/parent})].
[INTERVIEWER: IF RESPONDENT REFUSES: Your responses are strictly confidential and are not attached to any identifying information. It is important for us to know this information to help us describe people who took part in our study.]
[INTERVIEWER: IF RESPONDENT SAYS THEY ARE NOT SURE, PROBE: Can you estimate?]

D16A.‡ Is that less than (AMOUNT 2 M*) or (AMOUNT 2 M*) or more?
[INTERVIEWER NOTE: PLEASE READ NUMBER AMOUNTS SLOWLY AND CAREFULLY]

| | Wave 3 | |
|---|---|---|
| Less than/ =138% FPL | 55 | |
| Greater than 138% up to/ = 400% FPL (NET) | 37 | |
| Greater than 138% up to/ = 250% FPL | | 25 |
| Greater than 250% up to / = 400% FPL | | 11 |
| Greater than 138% up to/400% FPL (unspecified) | | * |
| Over 400% FPL | 6 | |
| Don't know/Refused | 1 | |

AMOUNTS USED FOR D15/D15A (BASED ON PERCENTAGES OF FPL GUIDELINES ROUNDED TO THE NEAREST THOUSAND)

| FamilySize | 100% Poverty guideline | AMT1 (138%) | AMT2 (250%) | AMT3 (400%) |
|---|---|---|---|---|
| 1 | $11,670 | $16,000 | $29,000 | $47,000 |
| 2 | $15,730 | $22,000 | $39,000 | $63,000 |
| 3 | $19,790 | $27,000 | $49,000 | $79,000 |
| 4 | $23,850 | $33,000 | $60,000 | $95,000 |
| 5 | $27,910 | $39,000 | $70,000 | $112,000 |
| 6 | $31,970 | $44,000 | $80,000 | $128,000 |
| 7 | $36,030 | $50,000 | $90,000 | $144,000 |
| 8 | $40,090 | $55,000 | $100,000 | $160,000 |
| 9 | $44,150 | $61,000 | $110,000 | $177,000 |
| 10 | $48,210 | $67,000 | $121,000 | $193,000 |


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# State Enrollment Experience: Implementing Health Coverage Eligibility and Enrollment Systems Under the ACA

*Alice M. Weiss and Kaitlin Sheedy*

## Key Findings

- Effective collaboration and coordination across state agencies and with the federal government was critical to states' success in moving toward the seamless and timely eligibility determinations envisioned in the ACA.
- Eligibility and enrollment changes of this magnitude, especially involving the adoption of new technology, often take longer than anticipated. Timelines may shift, policies may evolve, and unexpected challenges are likely to arise.
- Flexibility was a common theme among successful states. Throughout ACA implementation, these states stayed nimble, developing innovative solutions, responding quickly and adapting to the changing policy landscape.
- Keeping key stakeholders, including other state agencies and partners, involved and informed throughout implementation enabled speedier adaptation and provided continuous feedback that helped the state quickly identify and address emerging issues.
- A dedicated federal point person to answer agency questions is invaluable to states, especially in a fast-paced environment with continuously evolving policies and regulations. Regular and transparent communication among federal and state partners is key.
- Effective leadership and a culture that prioritized enrollment as a goal were important factors in many states.

The Patient Protection and Affordable Care Act (ACA) included new eligibility and enrollment requirements, which have presented states with significant implementation opportunities and challenges. Although states had choices about whether to host a health insurance exchange or expand Medicaid, the ACA required all states to make major changes to Medicaid eligibility policy, including adding mandatory coverage of new groups, implementing streamlined eligibility and renewal processes, incorporating new eligibility and verification requirements, and coordinating enrollment systems with exchanges.[1]

As a result, states had to create or significantly update existing systems, collaborate and coordinate with other state and federal agencies, and develop new processes to support enrollment. States implemented these changes within a constrained timeframe, with much activity occurring between the Supreme Court ruling in *NFIB v. Sebelius* in summer 2012 and the first open enrollment period in fall 2013. In addressing the challenges of ACA implementation, many states and federal agencies were highly innovative, developing approaches that set a new standard for promoting effective enrollment in public programs.

Drawing on key informant interviews and ongoing engagement with states between 2013 and 2015, this brief examines states' early experiences implementing the ACA's eligibility and enrollment requirements; highlights promising practices and lessons learned; provides some context on the state experience; and concludes with possible areas of focus for future enrollment and implementation efforts. With the recent Supreme Court decision in *King v. Burwell*, there is new momentum for state and federal agencies to learn from early experiences with ACA implementation to further improve enrollment systems in future years.

This brief offers reflections to support continued growth and movement.

# Streamlining Eligibility and Enrollment Processes Under the ACA

The ACA envisioned a simpler, unified system of health coverage. Through a sliding scale of subsidies and modernized enrollment processes, it sought to provide more affordable and accessible coverage options to non-elderly individuals with family incomes between 0 and 400 percent of the federal poverty level (FPL).[2] As part of promoting access to coverage, the ACA required all states to make transformative changes, modernizing and streamlining their eligibility and enrollment systems, many of which relied on decades-old technologies and paper-based processes.[3] Key changes included:[4]

- **Adding new coverage groups to Medicaid:** States were required to expand Medicaid coverage to children with family incomes up to 133 percent of the FPL and to young adults up to age 26 who were in foster care and enrolled in Medicaid when they turned 18. States also had the option to add Medicaid coverage for non-elderly adults with family incomes up to 133 percent of the FPL.[5]

- **Creating a streamlined, automated enrollment process:** States had to adopt a single, streamlined application (or alternative application approved by the Secretary of HHS) for Medicaid, Children's Health Insurance Program (CHIP), and subsidized qualified health plans (QHPs) offered through the marketplace. States also had to accept applications online, by phone, by mail, or in person, and states were barred from requiring in-person interviews and from asking for more than the minimum information necessary to determine eligibility. Although some states already used a simplified application or electronic processing for Medicaid and CHIP programs, for most converting applications and systems required a significant shift in business operations and substantial coordination with federal officials.

- **Implementing new income eligibility rules:** With support and guidance from the Centers for Medicare and Medicaid Services (CMS), states were required to adopt a new modified adjusted gross income (MAGI) methodology for income determinations and convert their income categories to the new MAGI standards. States also had to incorporate the ACA's income counting rules for American Indians/Alaskan Natives.

- **Changing verification processes:** States had to adopt a new coordinated data-driven system that relied on a federal data services hub for verification of income, citizenship, and immigration status, along with available state-based data sources. Although many states had relied on paper documentation to verify eligibility, the ACA regulations required states to prioritize electronic data sources. States were also required to allow applicants to self-attest their pregnancy status, and CMS clarified states' option to use self-attestation for other requirements, including residency. And, for the first time, states had to create a plan documenting their MAGI-based eligibility verification processes and sources used and submit it to CMS.

- **Coordinating with state and federal marketplace agencies:** States were required to screen eligibility and transfer applications to appropriate insurance affordability programs (Medicaid, CHIP, and marketplace). For applications transferred to Medicaid or CHIP, states had to make a timely determination without requiring additional information. To do this, states set up data-sharing agreements and needed to be able to transfer account information electronically.

- **Streamlining the renewal process:** States had to implement new, simpler renewal processes that lowered burdens on enrollees. As part of this effort, states had to rely, to the greatest extent possible, on available information; make renewal decisions without requiring additional information from enrollees; use

prepopulated, streamlined forms when there was insufficient information for renewal; allow individuals to renew electronically, by phone, in person, or by mail; and renew no more than once per year.

## State Choices Impacted Implementation

The extent of the changes required and how the new systems operate has varied based in part on each state's decision regarding marketplace functions. Sixteen states opted to enroll individuals through a state-based marketplace (SBM), where the state performs all marketplace functions; six states use a state partnership marketplace (SPM) model where the state performs consumer assistance, plan management functions, or both and the federal facilitated marketplace (FFM) manages eligibility determination processes; and the remaining 29 states rely on the FFM for all marketplace functions.[6]

In SBM states, the state performs eligibility and enrollment functions, usually through its own eligibility system, and manages plans and assistance organizations. In FFM states, the FFM performs all marketplace eligibility and enrollment functions relating to qualified health plans: eligibility, enrollment, plan management, consumer assistance and financial management. Although the FFM either assesses or determines Medicaid and CHIP eligibility for states, FFM state agencies remain responsible for other Medicaid and CHIP eligibility and enrollment systems and processes, including timely account transfers between federal and state systems. Consumers in FFM states can apply for and enroll in coverage through the FFM marketplace website, healthcare.gov, or enter through the state's Medicaid or CHIP systems. SPM states' enrollment functions operate like FFM states, except these states may perform plan management or consumer assistance functions, or both. Both FFM and SPM states need to coordinate closely with federal agencies to ensure seamless eligibility and enrollment operations.[7]

FFM and SPM states could opt to be either assessment or determination states for Medicaid and CHIP eligibility.[8] In assessment states, the FFM assesses an applicant's eligibility and state Medicaid and CHIP agencies make the final eligibility determination. In determination states, the FFM makes a determination of eligibility which the state Medicaid agency must accept and enroll the individual once an account is transferred. As of January 2015, 10 states had opted to be determination states and 27 states were assessment states.[9]

Assessment and determination states faced and adapted to different sets of challenges and functionality issues. For example, in the first year, the FFM had to transfer accounts using "flat files" that included basic information about applicants assessed or determined to be eligible for Medicaid or CHIP but did not capture enough information for states to make independent determinations.[10] As a result, assessment states had to gather additional information to support their own determinations. In addition, both groups of states reported that a significant percentage of individuals determined newly eligible for Medicaid by the FFM were already enrolled. These technical difficulties, combined with the volume of applications and the absence of fully automated systems created an enrollment backlog in some states as they manually worked through the case files.[11] Although FFM functionality was better during the second open enrollment period, interviewees said improvements are still needed.[12]

All state IT systems needed expanded capabilities. In many states, eligibility systems were outdated and the additional functions could not be added without building a new system or significantly updating an existing one. States are able to claim an enhanced federal match for developing their Medicaid IT systems: a 90 percent federal financial percentage (FFP) is available for design, development, and implementation of IT systems, and a 75 percent FFP is available for ongoing maintenance and operation.[13] To claim the enhanced match, states must have an approved advance planning document; comply with CMS's seven conditions and standards;[14] and appropriately allocate costs. States can also claim a 75 percent FFP for approved electronic eligibility determination system

operations, including staff time.[15]

Two Tri-Agency letters, sent jointly from CMS, the U.S. Department of Agriculture, and the Administration for Children and Families allow states to use the enhanced FFP to upgrade systems that support human services programs other than Medicaid, as long as the addition does not delay implementation of the ACA requirements and states appropriately allocate any additional costs of improvements for non-Medicaid programs.[16] Under this guidance, states can also allocate costs for development and maintenance of state marketplace IT systems that serve Medicaid eligibility functions.

## Promising Practices

States innovated and adopted new strategies that, according to interviewees, appeared to increase enrollment, improve efficiency or coordination, and make eligibility systems run more smoothly. Some examples of these practices are detailed in the text below.

## Targeted Enrollment

In anticipation of the first open enrollment period in 2014, CMS offered five targeted and streamlined enrollment strategies to help states manage the transition to new eligibility and enrollment systems:[17]

1. Implementing MAGI rules on October 1, 2013
2. Extending the renewal period for certain individuals
3. Facilitating enrollment through administrative transfers of eligibility data from other programs.
4. Enrolling parents based on children's eligibility.
5. Adopting 12 months of continuous eligibility (without regard to changes in circumstances) for parents and other adults through the Medicaid section 1115 waiver authority.[18]

These optional approaches were created to help states efficiently identify and enroll eligible individuals and alleviate administrative burdens during this high-volume period, and more than two-thirds of states implemented one or more of them.

Seven states used income data from the Supplemental Nutrition Assistance Program (SNAP) to identify Medicaid-eligible individuals.[19] Officials and stakeholders in Arkansas and West Virginia reported that using this strategy increased enrollment and contributed to smooth enrollment processes:

- In Arkansas, SNAP eligibility rules aligned with Arkansas' Private Option Medicaid expansion program and ARKids First, the state's CHIP program. Arkansas' Medicaid agency mailed letters to potentially eligible SNAP recipients that clearly listed all Medicaid-eligible individuals in the household. The state identified the individuals and mailing addresses from information already provided to the Department of Human Services (DHS), which administers both SNAP and Medicaid. To enroll, recipients simply signed and returned the letter to DHS. Once the state received the signed letters, officials automatically enrolled children in ARKids First and mailed an ID card and sent adults a plan selection letter, giving applicants up to 12 days to select a Private Option plan through the state's web portal or be enrolled in a default plan if they did not select one. Arkansas officials reported that they had enrolled 61,000 people, or roughly 40 percent of new Medicaid enrollees, using this strategy by the end of the first enrollment period.

- West Virginia also successfully used this strategy and credited this low-touch approach with about half of all Medicaid enrollments during the first year. The state initially sent letters with enrollment information to 118,000 SNAP recipients in September 2013. County staff and in-person assisters called to follow up on the mailing. The state then sent follow-up letters to 17,000 individuals in November 2013 and made another round of follow-up calls. Through this process, the state was able to enroll approximately 72,158 people, more than half of the 133,000 individuals who were newly enrolled during the first open enrollment period.[20]

## Eligibility System Functionality

The ACA catalyzed long-overdue improvements to state eligibility systems, many of which were out-

dated and featured cumbersome operations, high administrative costs, ineffective data use, obstacles for consumers, and other inefficiencies.[21] All the states represented in the interviews used the ACA's requirements and enhanced funding to modernize their systems. State officials reported that taking a proactive, tailored approach to system updates resulted in improved performance, greater efficiency, and reduced burdens for consumers and state workers. For example, Kentucky officials reported that Medicaid and marketplace officials coordinated heavily in the design and implementation of that state's IT system, including holding joint design and testing sessions and supporting close collaboration between the very "hands on" IT staff and policy staff throughout the process.

Several states that allowed extra time to test eligibility system technology before making it available to consumers reported positive results. For example, Ohio Medicaid officials reported delaying their system launch until December 2013 to test the functionality and said that as a result, the system performed well and gained consumer confidence at a critical time when FFM was underperforming. Connecticut officials reported that their system worked well because they started early and tested it multiple times before launch.

## Eligibility System Processing

The ACA assumes an eligibility process that allows applications and data to flow seamlessly across agencies to match customers with the appropriate health coverage program (usually either Medicaid, CHIP or subsidized qualified health plans purchased through an exchange). This kind of seamless processing would occur most easily within a single integrated system serving all programs. Twelve states had adopted such a system as of January 2015.[22]

Nearly all of these states also built automated "rules engines" that interface with the state and federal data sources needed to verify application information. Automated eligibility decisions, coupled with electronic verification using both federal and state data sources, enable states to conduct efficient, real-time eligibility determinations. Using integrated eligibility systems prevents delays in handoffs of information between the marketplace and Medicaid and CHIP eligibility systems.[23] Kentucky, one interviewed state that implemented an integrated system, reported that their state's integrated eligibility system and automated rules engine virtually eliminated miscommunication among programs in the eligibility process and improved efficiencies for state workers during the first year of open enrollment.

States are also working to integrate these modernized Medicaid and CHIP eligibility systems with other human service programs to identify and simplify enrollment for the millions of low-income individuals who are enrolled in assistance programs but not in Medicaid. For example, if all states expand Medicaid, more than 90 percent of recipients of SNAP, Temporary Assistance for Needy Families (TANF), and housing subsidies will qualify for Medicaid.[24] As of January 2015, 19 states reported that their Medicaid eligibility systems were integrated with at least one other human service program's system, and another 12 states were planning to integrate in 2015.[25]

## Coordination Among State Agencies and With Federal Partners

Several states reported that effective coordination among state agencies and with federal partners were key to strong enrollment performance.

- Arkansas officials, for instance, reported that Insurance Department and Medicaid officials coordinated closely on the development and implementation of their enrollment efforts, including through regular cross-agency meeting and reporting.
- Kentucky state officials reported that in 2010 they formed a team of staff from Medicaid, community-based services, TANF, Insurance, health policy, and IT that coordinated implementation through weekly meetings during implementation.
- Washington state officials also reported holding regular meetings with IT, Medicaid, Insurance, and marketplace officials and said that a key element of their success was their work

through that process to manage scope and governance and to tighten and clarify responsibilities.

All these states also reported close coordination and consultation with the Center for Consumer Information and Insurance Oversight (CCIIO) and the Center for Medicaid and CHIP Services at CMS.[26]

States also reported that having timely, accurate information from federal partners was essential, both to improving the accuracy of Medicaid and the FFM or state determination process and to lowering the resource burden for states. Although nearly all states praised federal agency partners' engagement and appreciated new structures to improve communication, some expressed concern that tight timelines and the rulemaking process in the first year of implementation limited their access to timely information.

States noted that the State Operations and Technical Assistance (SOTA) phone calls that CMS has hosted since spring 2012 are an effective model for communicating with and supporting states. CMS holds SOTA calls with state officials as a group and conducted monthly calls with individual states before and during ACA implementation, providing technical assistance and support on policy and operational issues. Subject matter experts are typically on the calls to provide updates and answer questions, which states said is especially valuable. Several states also praised CCIIO's support for implementation but expressed concerns about the rulemaking delays that created challenges during the first year when states had to scramble to make late changes to new systems in response to revised policies.

## Renewal Simplification Strategies

During the second year of open enrollment, states for the first time renewed QHP enrollees and enrolled new customers at the same time. Renewing coverage for existing enrollees is essential to avoid coverage gaps, but state approaches varied.[27] The ACA required states to ensure that renewal processes for Medicaid, CHIP and marketplace coverage are streamlined, integrated, and user-friendly. Several states reported that adopting auto-renewals, beginning the processing of QHP renewals before open enrollment, and using pre-populated forms helped streamline processes for agency staff and promoted continuity of coverage for consumers. Connecticut officials reported that using a QHP auto-renewal process, combined with other outreach, resulted in an 80 percent retention rate among those eligible to renew in the second year.

## Real-Time Feedback Loop and Transparency

A number of states reported that they scheduled weekly calls during the open enrollment period with organizations providing enrollment assistance to consumers and other stakeholders to get feedback and track problems with state and federal systems. These states said the calls helped them identify emerging issues, quickly address problems, and elevate concerns with federal agency partners where external help was needed. Some of these states also used the calls to share updates and changes to the system so that assistance organizations understood new systems and process changes. For example, California officials reported using periodic calls to update eligibility workers and consumer advocates throughout the state on changes to the system and to hear about issues and concerns. Before implementation, Washington state officials established monthly outreach meetings and provided trainings that reached over 1,900 community partners. During the first year of implementation, Washington officials organized Friday Forum meetings with assistance and stakeholder organizations to discuss the latest issues and areas for coordination. The state also continued holding community partner webinar trainings to discuss issues and system changes during the second year of implementation. Kentucky, Montana, and Ohio, also reported convening or participating in similar stakeholder meetings. Some states, most often those with state-based exchanges, also supported transparency in implementation by posting updates, information, and enrollment data on state websites.

### Managing Eligibility System Volume

During open enrollment periods, some states experienced higher than anticipated volume on newly launched eligibility systems, due in part to the success of consumer outreach strategies. High volume strained IT system and support staff. Some states worked to mitigate volume to reduce burdens and ensure effective distribution of resources. For example, in the second year, California and Idaho opened their marketplace sites early for renewals, and Oklahoma monitored call center and eligibility worker peak-flow times and reorganized staff and hours of operation to improve performance.

### Strong Leadership and Enrollment Culture

Although difficult to quantify as a success factor, several officials and stakeholders said their success was due in part to strong leadership from a state official and a culture that supported streamlined enrollment as a priority goal. Representatives from one assistance and provider organization said of their state's official, "[he] brought people together and worked really hard in a very difficult political environment. He helped forge partnerships and move things forward." Another official praised his state's agency director for being "proactive in reaching out to federal officials and asking questions." Stakeholders providing enrollment assistance mentioned that a significant factor in their success was that the marketplace was state-led and said that alignment around coverage as a policy goal helped move their work forward.

## Remaining Challenges and Future Opportunities

Although integrating and advancing state and federal eligibility and enrollment systems has presented historic challenges for state and federal agencies, achieving the ACA's policy and system goals has the potential to provide states with a less costly and more efficient, consumer-friendly, and effective means for enrolling and retaining eligible individuals. State and federal agencies continue to refine processes and systems in order to optimize the consumer experience, improve efficiency, and minimize confusion and administrative burdens on staff and stakeholder entities providing assistance. The federal government has made a significant investment in ensuring that processes are more streamlined and has demonstrated a strong commitment to working with states to further optimize system functionality. In making transformative changes, state leaders have shown themselves willing and able to think differently and to innovate around health coverage programs.

Looking to the future, state agency leaders identified key challenges and future opportunities to improve eligibility and enrollment operations in years ahead.

### Providing Accurate and Timely Technical Support and Communications

Several states reported ongoing challenges with receiving electronic account files from the FFM. Some states have found that the information contained in those files was inaccurate due to technical issues with the data hub and disconnects with state systems. Reported problems have included erroneous identity verification, failure to detect Medicaid-enrolled individuals, and cases where applicants "looped" between Medicaid and marketplace entities without a final determination of coverage. Although states interviewed praised the SOTA calls that CMS hosted and CCIIO's operational support, some said they wanted CMS to give state interests greater consideration in future implementation efforts and wanted a more streamlined process for elevating and resolving cases involving a pending eligibility decision. Many FFM states suggested it would be helpful to have federal technical experts to address questions related to eligibility systems or account transfer issues on SOTA calls. Officials said some IT system funding issues raised policy concerns but were handled just with state IT staff, and they wanted a venue for discussions that bridged policy and technical work. Some officials also mentioned wanting more opportunities for cross-state learning and information sharing and said that technical assistance would be valuable.

## Streamlining System Processes

Medicaid directors and CMS are working on a number of system and policy improvements to increase efficiency and improve communication between federal and state agencies, including stabilizing system timelines and testing, eliminating redundancies between state and federal systems, improving formats, for shared information upgrading notices and communication about coverage, and aligning eligibility policies.[28] A high-priority request for states is that the FFM perform a "Medicaid Check" for applicants identified as Medicaid eligible by the FFM before transfer to the state. In some states, the FFM's transfer of Medicaid-eligible individuals led to additional costs, dual enrollment in Medicaid and the marketplace, or consumers who looped back and forth between both systems. Some states and stakeholders also had concerns about the number of cases where coverage decisions were delayed or unresolved because of discrepancies between how state and federal agencies determined eligibility and challenges with tracking a case to resolution.

Some states are still deploying technology to make them fully compliant with the ACA's requirements, and officials will need to invest time and resources to ensure that their own systems and processes are efficient, leverage existing data and technology to the greatest extent possible. To support that goal, states may look for opportunities to simplify eligibility processes by aligning systems with other human service programs, engaging in process-mapping efforts or secret shopper reviews to identify and resolve gaps, and investing in emerging technologies to support a streamlined experience. For example, Kentucky officials are planning to implement a new system for the next open enrollment period that will use text messages to send information and reminders to applicants in rural areas, who may be more likely to have access to cell phones than computers.

## Improving Eligibility Verification Systems

Many states continue to have challenges with eligibility verification. Due to delays in system functionality and issues with integration across state, federal and, in some cases, county-based systems, many states still have to manually review cases for accuracy and have ongoing problems with income and citizenship verification. Although some states are already using electronic connections to create a state data hub for verification purposes, other states aren't yet fully utilizing the data available from other state programs. States have also expressed great interest in being able to access the federal data services hub, which provides social security and tax-based income information for applicants, across health and human services programs, to integrate and align eligibility verification processes. Sharing hub information is currently barred by federal rules that protect personal tax information, so a policy change would be needed to allow greater integration. Continued communication between federal and state officials to identify issues and challenges with the federal data hub will likely improve its functionality in future years.

## Tracking and Managing Coverage Gaps and Errors

Most states that were interviewed for the first open enrollment period did not yet have systems in place to track eligibility changes, midyear transfers, reasons for coverage loss, or the outcome of eligibility changes (e.g., loss of coverage or transfer to another coverage program). However, states' experiences with Medicaid and CHIP enrollment suggest that loss of coverage due to eligibility changes or failure to renew is a significant risk for low-income populations.[29] Individuals who lose coverage but remain eligible will likely re-enroll, creating a phenomenon known as "churn," disrupting continuity of coverage for individuals, undermining states' ability to monitor and improve health outcomes, and increasing administrative costs. State and federal agencies can focus on improving tracking of reasons for coverage loss and the outcome of eligibility changes throughout the year and at renewal, to improve their capacity to understand coverage trends and whether procedural barriers are a factor in disenrollment.[30] Another important area for future tracking is states' experiences with erroneous enrollments and their financial impact, in unnecessary payments and fines. Increasing state and federal ca-

pacity to track and understand these trends will be essential to ensure that the ACA's investment in coverage yields lasting coverage gains.

### Financing and Sustaining Systems

Several states reported that funding for eligibility and enrollment efforts was constrained, either due to limits on Medicaid budgets or expiring federal support for state-based marketplaces. Some states reported finding successful solutions involving external partners, such as leveraging financial or in-kind support from state-based foundations. In Ohio, a private foundation hosted and supported a coalition of interested stakeholders to work with the state on ACA implementation. In California, a private foundation provided the state share of Medicaid matching funds needed to finance state outreach efforts. SBMs are considering policy options to provide financial sustainability in 2016. Some SBMs have implemented or are pursuing cost-reimbursement strategies to ensure that costs associated with the significant percentage of Medicaid eligibility cases handled by marketplaces entities are accurately allocated to Medicaid.[31]

## Conclusion

Over the past few years, state and federal officials have undertaken the historic task of modernizing and streamlining eligibility and enrollment systems to meet ACA requirements to improve access to coverage for low-income individuals. This brief highlights some of states' early promising practices, lessons learned, remaining challenges, and future opportunities for state and federal officials to consider as they move forward. With the Supreme Court's decision upholding the constitutionality of federal marketplace subsidies in FFM states in *King v. Burwell*, states have greater certainty about the continued availability of ACA coverage programs, which may offer new momentum for federal and state agencies to invest new resources in learning and improving enrollment systems for future years. Regardless of future roles for state and federal agencies under the ACA or other programs, state lessons about investing in system improvements, coordination among agencies and stakeholders, strong leadership that can remain flexible and adaptive in a dynamic environment, and creativity in the face of logistical and other challenges, are valuable models for future implementation.

## Methodology

Between 2013 and 2015, NASHP, with funding from the Robert Wood Johnson Foundation, investigated the experiences of federally facilitated marketplace (FFM) states—states using the federal health insurance exchange—working to prepare for and enroll consumers in coverage under the ACA. In 2013, NASHP hosted a meeting of FFM state officials. In spring 2014, NASHP conducted key informant interviews with state officials and stakeholders in 10 states that had successful enrollment and proportionally represented state exchange and expansion choices (Arkansas, California, Connecticut, Florida, Kentucky, Ohio, Montana, North Carolina, Washington, and West Virginia). The group included six FFM states (including three SPM states) and four SBM states.[32] To get a broader perspective, NASHP sought to interview at least three representatives in each state: two state officials from different agencies, either Medicaid, CHIP, or Insurance Departments, and one stakeholder involved with enrollment activities. NASHP also facilitated a learning network of FFM state leaders on a bimonthly basis throughout 2014 and convened an in-person meeting at its 2014 State Health Policy Conference. Finally, NASHP hosted a webinar in December 2014 and surveyed key informants from the 10 states in early 2015 to identify strategic changes and lessons learned from the second open enrollment period.

## End Notes

1. Alice M. Weiss, Abigail Arons, and Julien Nagarajan, States' Medicaid ACA Checklist for 2014, (Washington, DC: National Academy for State Health Policy, State Health Reform Assistance Network, and Robert Wood Johnson Foundation, 2013).

2. Alice M. Weissand Laura Grossman, Paving and Enrollment Superhighway: Bridging State Gaps Between 2014 and Today, (Washington, DC: National Academy for State Health Policy, California Healthcare Foundation, 2011).

3. Ibid.

4. Alice M. Weiss, Abigail Arons, and Julien Nagarajan, States' Medicaid ACA Checklist for 2014.

5. Although the ACA originally required states to expand Medicaid coverage to non-elderly adults with family incomes up to 133 percent of the federal poverty level, the Supreme Court's decision in NFIB v. Sebelius made that requirement unenforceable by HHS and many states opted out of the expansion. As of June 2015, 30 states had chosen to expand Medicaid coverage to this new adult group.

6. State Refor(u)m, Where States Stand on Exchanges (Washington, DC: National Academy for State Health Policy, 2014). Three SBM states are relying on the federal marketplace as an eligibility system IT platform for the 2015 plan year and three FFM states are operating state-based Small Business Health Options Program (SHOP) exchanges.

7. Stan Dorn and Rebecca Peters, Opportunities under the Affordable Care Act for Human Services Programs to Modernize Eligibility Systems and Expedite Eligibility Determination, (Washington, DC: Urban Institute, 2014).

8. Kaitlin Sheedy, Coordinating Eligibility and Enrollment: Assessment vs. Determination Model (Washington, DC: National Academy for State Health Policy, 2013); Brooks, Tricia, Tech Tuesday: Medicaid Assessment or Determination by the Federal Marketplace, Center for Children and Families Health Policy Blog (June 4, 2013) http://ccf.georgetown.edu/all/tech-tuesday-medicaid-assessment-or-determination-by-the-federal-marketplace.

9. Tricia Brooks, et. al, Modern-Era Medicaid: Findings from a 50 State Survey on State Eligibility, Enrollment, Renewal and Cost-Sharing Practices as of January, 2015 (Washington, DC: Kaiser Family Foundation, 2015). This number includes all 34 FFM/SPM states, plus the three SBM states that are using healthcare.gov to support eligibility functions.

10. Center for Medicaid and CHIP Services, State Medicaid Director Letter, New Flexibility: Using Account Transfer Flat Files to Enroll Individuals in Medicaid and CHIP. (Washington, DC: Department of Health and Human Services, 2013).

11. States that experienced enrollment system challenges or were unable to process cases within the 45-day timeframe required by CMS to develop and submit mitigation plans that outlined the state's efforts to address the barriers to compliance.

12. Medicaid directors have voiced similar concerns in a March 2015 letter to CMS. In that letter, state Medicaid directors shared with CMS a list of priority improvements to increase the accuracy of FFM determinations and the efficiency of federal and state operations for the 2016 open enrollment period. National Association of Medicaid Directors: letter to the Centers for Medicare and Medicaid Services, March 23, 2015, http://medicaiddirectors.org/sites/medicaiddirectors.org/files/public/namd_letter_to_cms_medicaid_exchange_issues_150323.pdf. CMS later expanded the scope of data sent to states to include enough information to support a determination, including Social Security Numbers and dates of birth. Among the prioritized improvements was a request that the FFM check Medicaid enrollment at the beginning of the eligibility determination process to avoid duplicate enrollments.

13. U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Federal Register 76, no. 75 (April 19, 2011). pp. 21949 – 21975.

14. Centers for Medicare and Medicaid Services, Enhanced Funding Requirements; Seven Conditions and Standards (Washington, DC: U.S. Department of Health and Human Services, 2011), MITS-11-01-v1.0.

15. 42 USC § 433.116(j). Medicaid Program Eligibility Final Rule (2011). Although the 90 percent FFP for IT system development and implementation was originally only available for costs incurred or services performed through December 31, 2015, CMS proposed in April 2015 to extend the availability of the enhanced FFP indefinitely and to extend funds for integrated systems until 2018. In proposing to extend the funds, CMS recognized that state eligibility and enrollment systems are in varying stages of completion and reasoned that an extension would enable states to further improve and integrate systems. Centers for Medicare and Medicaid Services, Proposed Rule: Medicaid Program: Mechanized Claims Processing and Information Retrieval Systems (Washington, DC: Department of Health and Human Services, 2014), RIN 0938-AS53.

16. U.S. Department of Health and Human Services, Federal Policy Guidelines: Letter to State Exchange Grantees; Medicaid and CHIP Directors; Health and Human Service Directors, January 23, 2012.

17. Center for Medicare and Medicaid Services, State Health Officials Letter; State Medicaid Director's Letter: SHO #13-003; ACA #26, Facilitating Medicaid and CHIP Enrollment and Renewal in 2014, May 17, 2013.

18. Centers for Medicare and Medicaid Services, Targeted Enrollment Strategies (Washington, DC: Department of Health and Human

Services, 2014). Most states (36) opted to delay renewal periods, with fewer choosing to implement other strategies. No states implemented the continuous eligibility strategy for adults.

19. Ibid. Arkansas, California, Illinois, Michigan, New Jersey, Oregon, and West Virginia used data from the Supplemental Nutrition Assistance Program (SNAP) to identify Medicaid-eligible individuals.

20. West Virginia Department of Health and Human Resources, "Second Round of Medicaid Automatic Enrollment Letters Sent," news release November 21, 2013, http://www.wvdhhr.org/communications/news_releases/Press%20Release--Secretary%20Bowling%20Announces%20Second%20Round%20of%20Automatic%20Enrollment%20Letters%20for%20Medicaid.pdf

21. Phone interview with WV Medicaid Officials, May 21, 2014; Stan Dorn and Rebecca Peters, Opportunities under the Affordable Care Act for Human Services Programs to Modernize Eligibility Systems and Expedite Eligibility Determination.

22. Tricia Brooks, et. al, Modern-Era Medicaid: Findings from a 50 State Survey on State Eligibility, Enrollment, Renewal and Cost-Sharing Practices as of January, 2015.

23. Manatt, Report from the States: Early Observations about Five State Marketplaces (Los Angeles, CA: State Health Network, 2013) .

24. Stan Dorn, et al., Overlapping Eligibility and Enrollment: Human Services and Health Programs Under the Affordable Care Act (Washington, DC: Urban Institute, 2013).

25. Tricia Brooks, et al., Modern-Era Medicaid: Findings from a 50 State Survey on State Eligibility, Enrollment, Renewal and Cost-Sharing Practices as of January, 2015.

26. CMS used a variety of strategies to address states' technical and operational challenges. For example, it leveraged the Eligibility Technical Assistance Group, a monthly forum where state Medicaid and CHIP leaders discuss eligibility policy and operational changes, highlight emerging implementation strategies and hear concerns. CMS also developed learning collaboratives, including one for FFM states, to gain a deeper understanding of state operations and develop new policies to address state needs. To engage state Medicaid, CHIP, Insurance, and IT teams, CMS created monthly State Operations Technical Assistance (SOTA) calls, group technical assistance meetings, and gate reviews in state-based exchange states to review state progress toward exchange development milestones. These convenings provided important opportunities for state agencies and federal partners to develop new policy strategies, discuss challenges and future needs, and provide support.

27. State Refor(u)m, Marketplace Renewal Strategies During the ACA's Second Open Enrollment Period (Washington, DC: National Academy for State Health Policy, 2015).

28. National Association of Medicaid Directors: letter to the Centers for Medicare and Medicaid Services, March 23, 2015.

29. Jessica Stephens and Samantha Artiga, Getting into Gear for 2014: Key Lessons from Medicaid and CHIP for Outreach and Enrollment Under the ACA (Menlo Park, CA: Kaiser Family Foundation, 2013).

30. All states are participating in a Medicaid and CHIP Eligibility Review Pilot, which allows the states and CMS to review the accuracy of caseworker and system determinations. This pilot, is intended to help states more rapidly identify and correct system and process errors and is replacing Payment Error Rate Management eligibility reviews for all states until 2017.

31. Electa Draper, "Colorado Health Insurance Exchange Could Double its Fees in 2016," Denver Post, May 11, 2015. At least four large SBMs are cost-allocating to Medicaid, with reimbursements ranging from $15 million to $29 million, according to an exchange official in Colorado, which is planning to implement Medicaid cost-reimbursement in 2016.

32. The 10 key informant states interviewed included six FFM/SPM states: Arkansas, Florida, Montana, North Carolina, Ohio, and West Virginia; and four SBM states: California, Connecticut, Kentucky, and Washington.

**About the National Academy for State Health Policy:**

The National Academy for State Health Policy (NASHP) is an independent academy of state health policymakers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice. As a non-profit, non-par- tisan organization dedicated to helping states achieve excellence in health policy and practice, NASHP pro- vides a forum on critical health issues across branches and agencies of state government. NASHP resources are available at: www.nashp.org.

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Stateline

# States Limiting Patient Costs for High-Priced Drugs

July 02, 2015

By Michael Ollove

States are beginning to limit what patients pay out of pocket for expensive specialty drugs that treat serious, chronic diseases such as rheumatoid arthritis and multiple sclerosis. (AP)

As more expensive specialty drugs come on the market to treat some of the most serious chronic diseases, more states are stepping in to cushion the financial pain for patients who need medicine that can cost up to hundreds of thousands of dollars a year.

At least seven states — Delaware, Louisiana, Maine, Maryland, Montana, New York and Vermont — limit the out-of-pocket payments of patients in private health plans. Montana, for instance, caps the amount that patients pay at $250 per prescription per month. Delaware, Maryland and Louisiana set the monthly limit at $150 and Vermont at $100. Maine sets an annual limit of $3,500 per drug.

New York prevents insurers from listing specialty drugs in a separate category that allows for charging higher payments out of pocket.

In an effort to hold down prices, legislators in other states, including California, Massachusetts and North Carolina, have proposed requiring companies to make broad financial disclosures justifying their high drug prices. So far, no such law has passed.

Critics of pharmaceutical pricing say that while the measures would help bring financial relief to some patients, they would fail to control spiraling drug prices set by drugmakers. As expensive specialty drugs proliferate, consumers likely will incur higher out-of-pocket payments and health insurance premiums.

“None of those measures is going to be very effective in my view because they don’t get at the underlying issue of how drug prices are set,” said John Rother, president and CEO of the National Coalition on Health Care, a nonprofit that focuses on improving health care while lowering costs.

## Expensive Class of Drugs

Specialty drugs are in a class called biologics, extremely complex medicines made from organic materials. They are often used to treat serious, chronic diseases, including some advanced forms of cancer, autoimmune diseases such as rheumatoid arthritis and diseases of the central nervous system such as multiple sclerosis. They also are used to treat hepatitis C, which afflicts approximately 2.7 million Americans, according to the Centers for Disease Control and Prevention.

In most cases, biologics are far more effective and cause fewer side effects than conventional drugs, leaving patients with no alternative but to take them.

But the price for these drugs far exceeds that of conventional drugs, largely because they have little or no competition. They also require special handling, such as refrigeration, and often must be administered intravenously, adding to their costliness.

On average, biologics cost 22 times what conventional medicines do. A 2011 AARP Public Policy Institute report said that the average specialty medicine cost more than $34,550 for a year's course of treatment.

"The cost of these drugs is simply unsustainable," said Leigh Purvis, director of health services research in AARP's Public Policy Institute.

Biologics also are gaining a growing share of the prescription market. According to a report last year from Express Scripts, a large prescription management company, specialty drugs already represent nearly a third of the spending on pharmaceuticals in the U.S., although they represent only 1 percent of all prescribed medications. Within two years, Express Scripts projects that spending on specialty drugs will account for $4.40 out of every $10 spent on medicine.

## Coinsurance Limits

At least seven states are tackling the problem of high out-of-pocket payments for expensive specialty drugs by limiting coinsurance payments.

Insurers use coinsurance and copayments to impose cost-sharing on beneficiaries. Copayments are a set price — often $5, $10, or $15 — that patients pay for medicine, whatever the cost of the drug. With coinsurance, patients are required to pay a percentage of the actual cost of the drug. That means that the higher the cost of the drug, the more the patient has to pay out of pocket.

Coinsurance payments for specialty drugs range nationally from 28 to 50 percent of the price of a drug, according to a 2013 policy paper by Chad Brooker, a lawyer with the Connecticut health exchange.

The state-imposed caps apply both to copayments and to coinsurance. They provide some price protection for the patients taking the drugs, but also spread the high cost of the drugs to a wider population of consumers in the form of higher insurance premiums.

“The caps don’t actually lower the costs of the medicine, it just raises the premiums for everyone,” said Rother of the National Coalition on Health Care.

Covered California, that state’s health exchange, this year became the first state exchange in the country to impose a coinsurance cap on specialty drugs of $250 per prescription per month.

James Scullary, a spokesman for Covered California, said the cap would result in an overall premium increase of no more than 1 percent in the first year and no more than 3 percent in the first three years.

New York has taken a slightly different approach. It won’t allow insurers to put biologics in their own special category of drugs. Insurers place medications in separate tiers depending on whether they are generics, preferred prescription drugs or specialty

drugs. The higher the tier, the greater the cost-sharing burden for the patient. New York has prohibited the use of the specialty tier.

In Delaware, the state forbids insurers from putting all specialty drugs for a particular disease in the specialty tier, so that patients are given at least one lower-cost alternative.

Neither method gets around the problem of higher premiums for everyone, Rother said. He and other critics call for another method of setting the price of prescription medicine.

Right now, drug prices are set by manufacturers subject to mandated discounts for various federal health plans and Medicaid, and through negotiation with other health plans. Critics have argued for a system of pricing based on the relative effectiveness of each drug.

## 'Shaming' Drugmakers

A bill currently before the California Assembly would require drugmakers to report their costs for the development and manufacture of any drug with a price tag of more than $10,000 for a course of treatment. Massachusetts and North Carolina are considering similar measures.

The purpose of disclosure measures is to create pressure on the drug companies to lower their prices, AARP's Leigh Purvis said.

"It's meant to be educational and also to be used in kind of a shaming way," she said. "If the manufacturer can't produce information that makes the prices seem justifiable, it may give people more ammunition to say that they're not."

The pharmaceutical industry argues that transparency laws, which it opposes, would not provide a fair representation of what it costs drugmakers to develop new drugs. For every drug that makes it to market, the industry says, nine or 10 do not. Nor would

disclosure provide information on what costs patients would have to bear, it says.

“All of [the proposed transparency laws] would create an inaccurate and misleading overview of costs of providing treatment, and don’t provide information on costs patients will have to pay out of pocket,” said Priscilla VanderVeer, a spokeswoman for the Pharmaceutical Research and Manufacturers of America.

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THE HENRY J. KAISER FAMILY FOUNDATION

REPORT

August 2015

# 2015 Survey of Health Insurance Marketplace Assister Programs and Brokers

Prepared by:

Karen Pollitz, Jennifer Tolbert, and Rosa Ma

Kaiser Family Foundation

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# Executive Summary

Now in second year, a new infrastructure of consumer assistance in health insurance continues to develop. The Affordable Care Act (ACA) provided for new publicly funded consumer assistance entities to help people on an ongoing basis as they apply for health coverage and subsidies and resolve questions and problems with their insurance once covered. Nearly all Marketplace Assistance Programs established for the first year returned this year to continue helping consumers. These assistance professionals have unique insights into how ACA implementation is progressing, what is changing and what challenges remain. How Assister Programs develop in their own right will also likely impact whether consumers can continue to get the help they need.

This report is based on findings from the 2015 Kaiser Family Foundation survey of Health Insurance Marketplace Assister Programs and Brokers. The online survey was conducted from March 31 to May 3, 2015 as the second Open Enrollment period concluded. As was the case last year, Federal and state-operated Marketplaces provided contact information for directors of their Assister Programs, all of whom were invited to participate. Two years of data enable comparison of Assister Programs capacity and experiences from one year to next. This year's survey also included brokers for the first time. Brokers have traditionally helped consumers enroll in private health insurance coverage. In 2014, many brokers registered to sell coverage through the Marketplace, and nearly all of them returned this year, as well. Returning brokers also offered some observations about how this year compared to the first year, and how it compared to their experience selling non-group coverage prior to ACA.

**Ninety-one percent of Assister Programs and 86% of brokers this year had also helped Marketplace consumers last year, and most (82% of Assister Programs and 79% of brokers) who returned said the second open enrollment period went better than the first.** In particular, Marketplace websites worked better this year. In 2014, 65% of Assister Programs said most or nearly all consumers sought help, in part, because of technical difficulties with the Marketplace website. This year, 38% of Programs said this was the case. In 2015, more Assister Programs reported they could complete the enrollment process with consumers and see their plan choice (71% vs. 61%) Returning Assister Programs had also gained a year of experience. By comparison, when the first Open Enrollment period began, only 16% of Assister Programs had previously helped consumers enroll in private health insurance.

**More than 4,600 Assister Programs served Marketplace consumers in the second year of health reform, collectively employing 30,400 full time equivalent staff and volunteers.** The overall number of Assister Programs and staff increased slightly in the second year. Similar to last year, 15% of Assister Programs were Navigators, funded directly by the Marketplace, while Assister Programs in Federally Qualified Health Centers (FQHCs), supported by grants from the Health Resources Services Administration (HRSA), comprised another 25% of total Programs. Certified Application Counselor (CAC) Programs, which are mostly supported by their sponsoring non-profit organizations or foundations and do not typically receive direct government support for assistance activities, comprised 60% of total Programs, and more than 50% of FTE staff. In terms of consumers helped, Navigators and FQHCs provided assistance to the majority of consumers reached during the second open enrollment period. Together, Navigators and FQHCs served 70% of all consumers who received help this year (30% and 40%, respectively), while CACs provided assistance to only 30% of consumers helped.

**Assister Programs helped an estimated 5.9 million consumers this year. Returning Programs helped 5.8 million of those, or about 19% fewer than last year.** This decline was driven by a large drop in the number of people helped by returning CACs. Collectively, returning Navigator and FQHC Assister Programs this year helped about the same number of consumers they reported helping last year (4 million vs. 4.1 million), while returning CAC Programs helped 1.8 million individuals, 60% of the number they helped last year. These differences suggest that Assister Programs supported by outside grant funding may be in a better position than voluntary Programs to help more consumers and to sustain their capacity over time.

**The need for in-person consumer assistance remains substantial.** Website improvements notwithstanding, millions of consumers continue to need personalized help to apply for health coverage and subsidies. Seventy-nine percent of Assister Programs this year (and 80% last year) said most or nearly all consumers sought help because they lacked confidence to apply on their own; 82% of Programs this year (83% last year) said most or nearly all consumers needed help understanding their plan choices; 74% of Assister Programs (this year and last year) said most or nearly all consumers needed help understanding basic insurance terms, such as "deductible." In addition, this year, like last year, most Assister Programs said it took one to two hours, on average, to help each consumer who was new to the Marketplace. Programs said it took somewhat less time, about an hour on average, to help consumers who were returning to renew Marketplace coverage and subsidies.

**Consumer demand for help exceeded what some Programs could provide this year, though not by as much as last year.** About one-in-five Assister Programs reported having to turn away at least some consumers this year. For the Open Enrollment period overall, 19% of Programs said they could not help all who sought assistance; during the final two weeks, 22% said they had to turn at least some consumers away. This contrasts with the first year, when 37% of Programs were stretched beyond capacity during Open Enrollment overall, and nearly half had to turn away at least some consumers during the final two weeks. It appears the availability of Marketplace consumer assistance is aligning with demand; however, additional capacity may still be needed.

**In between Open Enrollment periods, returning Assister Programs helped an estimated 630,000 consumers apply for coverage through special enrollment periods, 290,000 consumers report mid-year changes to the Marketplace, and nearly 800,000 consumers resolve post-enrollment problems.** The need for consumer assistance is year-round. Changes in work or family status or income during the year mean some people must enroll in coverage outside of Open Enrollment or apply for new or revised subsidies mid-year. Marketplace Assister Programs are tasked with helping consumers at these times as well. In addition, consumers need help once enrolled, including with questions about how to use their new health insurance, or what to do if their provider is not in network, or if a claim is denied. Under the ACA, state ombudsman or Consumer Assistance Programs (CAPs) were established to provide post-enrollment assistance, though CAP funding has not been appropriated since 2010. Most Assister Programs, therefore, try to help Marketplace consumers with their post-enrollment problems, and 69% said they could successfully resolve problems most of the time.

**Assister Programs report further improvements are still needed in Marketplace websites and Call Centers, and other technical assistance could be strengthened.** Most Marketplace online eligibility systems, especially in FFM states, are not yet integrated with Medicaid, so the single, streamlined application for financial assistance envisioned under the ACA is not yet a reality. As a result, when Marketplaces determine a consumer is likely eligible for Medicaid or CHIP, a new separate application is often required. Sixty-nine percent of Assister Programs will help consumers complete a separate Medicaid application. Most say this can be accomplished during the initial visit, but 45% of Programs say a one or more additional visits are needed, on average, to complete the Medicaid or CHIP application and enrollment process.

Assister Programs also cite the need for better information on health plan choices. Thirty-one percent of Programs this year said it was often or almost always the case that consumers had QHP questions that weren't answered by information on the Marketplace website. (Last year, 41% of Programs said this was the case.)

Programs also reported that technical assistance from the Marketplace Call Centers can be uneven. Half of Programs who said they reached out to Call Centers for help with translation services said help was effective most or all of the time. Among those who sought technical assistance with immigration questions, tax-related questions, or questions about QHP choices, less than half (41%, 45%, and 39%, respectively) said that Call Center technical assistance was effective most or all of the time.

**Coordination among Assister Programs remains an important, but elusive goal.** Ninety percent of Assister Programs said coordination with other Programs is somewhat or very important to their effective operation, but just over half of respondents said they seldom if ever coordinate with other Assister Programs. When coordination did take place this year, similar to last year, most often it was initiated by Assisters themselves or by an outside third party, not by the Marketplace.

**Funding uncertainty concerns many Assister Programs.** Twenty-seven percent of Assister Programs said they are very certain that funding will be available to support them next year, while 39% are not certain at all. Overall, Marketplaces provided fewer funding resources for Assister Programs in the second year. The federally run Marketplace cut funding available for Assister Programs in FFM and FPM states by about 10% this year from $67 million in FY 2014 to $60 million in FY 2015. Many State-based Marketplaces also reduced their Navigator funding from first year levels; in all state-Marketplace funding for Navigators fell by about 15 percent. The Centers for Medicare and Medicaid Services (CMS) has announced $67 million will be available for Navigators in FFM/FPM states in year three – the same amount awarded in year one and a 12% increase over year two funding levels. CMS has also indicated there will be additional, as yet unspecified, funding for Federal Enrollment Assistance Programs (FEAPs), which supplement the work of Navigators in some FFM states, in year three. Many state-based Marketplaces have yet to decide the level of consumer assistance resources they will fund in year three.

**Health insurance brokers continue to help many consumers apply for coverage, mostly through Marketplaces.** Before the ACA, private health insurance brokers traditionally offered help to consumers seeking non-group coverage, and they continue to play an important role today. Brokers are paid commissions by insurance companies for each policy they sell. Many are certified to sell non-group coverage through the Marketplace, and this year, the survey included Marketplace-certified brokers (referred to simply as "brokers" in this report.) The vast majority of brokers who sold non-group coverage this year had done so during the first

Open Enrollment period and prior to 2014, as well. Most (79%) sold non-group coverage both inside and outside of the Marketplace, though on average, brokers helped almost twice as many consumers apply for coverage through the Marketplace compared to outside.

**Non-group sales have increased for most brokers since Marketplaces opened in 2014.** Sixty percent of brokers say they are selling more non-group coverage today than they did prior to 2014. Most reported it takes more time to sell a policy and the revenue they earn per-policy is less; but 40% earn more income overall from non-group commissions than they did prior to implementation of the Marketplaces and another 20% said their overall non-group commission income is about the same.

**Brokers and Assister Programs engage in similar consumer assistance activities, with some differences.** Both brokers and Assisters help consumers complete Marketplace applications, compare plan choices, and answer tax-related questions. Both also help consumers with post-enrollment problems. However, compared to Assister Programs, brokers less often engage in public outreach and education activities. Brokers also provide less help to consumers applying for Medicaid and more help to small businesses seeking small-group coverage.

**Brokers and Assister Programs appear to serve somewhat different populations.** Brokers were less likely than Assister Programs to serve Latinos, consumers who needed language translation help, consumers who lacked Internet service at home, or consumers with incomes low enough to be eligible for Medicaid. Brokers were also less likely than Assister Programs to say that most of their clients were uninsured at the time they sought help. However, returning brokers reported a higher degree of client continuity from year one compared to Assister Programs, indicating they may be establishing more ongoing relationships with their clients than Assister Programs have been able to do so far.

# About the Assister Programs and Brokers Described in this Report

Several types of Assister Programs provide outreach and enrollment assistance in the Marketplace.

**Navigator** refers to Assister Programs that contract directly with State Marketplaces or with federally facilitated Marketplace to provide free outreach and enrollment assistance to consumers. The ACA requires all Marketplaces to establish Navigator Programs and to finance Navigators using Marketplace operating revenue. For the first Open Enrollment, before Marketplaces had received any operating revenue, SBMs were permitted to use federal exchange grant funding to establish similar Programs, called In Person Assisters (IPAs). Now that those state grants have ended, this year's report does not distinguish between IPAs and Navigators; instead, all Assister Programs funded directly by Marketplaces are referred to as Navigators. CMS provided $60 million for Navigators to work in 34 FFM and FPM Marketplaces in the second year, compared to $67 million in year one.[1] SBM states and consumer assistance FPM states provided over $100 million in funding for their IPA and Navigator Programs in year one.[2] However, with the termination of federal grant funding to support consumer assistance, overall state spending on these Programs dropped about 15 percent in year two.[3]

**Certified Application Counselor (CAC)** refers to Assister Programs that are recognized by a Marketplace but do not receive funding from a Marketplace. This designation was created prior to the first Open Enrollment – when funding for Marketplace-paid assisters, at least in the FFM, was still uncertain – to ensure that willing volunteer Programs would also be available to help. CACs must be sponsored by an organization that will attest to the Marketplace that all of its individual Assisters meet minimum requirements. CACs also must provide help to consumers free of charge. Under federal rules, CACs are not required to engage in all activities required of Navigators, and they are not required to undergo training as extensive as that required for Navigators. All Marketplaces are required to recognize and certify CAC Programs, and states have flexibility to establish additional rules for CAC Programs. Although not funded by the Marketplace, many CAC Programs received funding from other outside sources.

**Federally Qualified Health Center (FQHC)** Programs are operated by health centers funded by the Health Resources and Services Administration (HRSA). FQHCs treat patients regardless of ability to pay and, prior to enactment of the ACA, actively helped patients apply for Medicaid, CHIP, or other available coverage. For the first year of ACA implementation, HRSA awarded $208 million to FQHCs to support enrollment assistance. In the second year, HRSA made permanent enrollment assistance grants to FQHCs totaling about $150 million per year. All FQHC Assisters are required to complete at least the level of training required of CACs. About 6% of FQHCs also serve as Navigators and so received Marketplace funding in addition to HRSA grants. For purposes of this report, FQHCs that also receive Marketplace funding are referred to as Navigators.

**Federal Enrollment Assistance Program (FEAP)** refers to Assister Programs that contracted with CMS to provide supplemental enrollment help within FFM and FPM states in selected communities where large numbers of uninsured individuals reside. Duties and requirements of FEAPs are similar to those of federal Navigators except that FEAPs provide "surge" assistance. Most have rolled back staff and operations since Open Enrollment ended. In this report, unless otherwise indicated, description of findings about Navigators will include FEAPs because the two types are so similar. For the 2015 coverage year, CMS awarded contracts totaling about $29 million to two organizations to establish FEAPs in 10 states.[4] FEAP contracts were initiated

for the 2014 plan year with an option for CMS to elect a second year of work. CMS will continue to contract with FEAPs in year three, though the contract amount and work sites have not yet been determined.

Finally, in addition to Marketplace Assister Programs, the ACA authorized creation of state-based ombudsman programs, also called Consumer Assistance Programs, or CAPs. The law requires CAPs to provide outreach and public education and provide enrollment assistance to consumers in the Marketplace. In addition, CAPs must help all state residents resolve questions and disputes with their private health insurance coverage, including helping consumers to appeal denied claims. The ACA requires Marketplace Assisters to refer consumers with post-enrollment problems to state CAPs. The law provided initial funding for states to establish CAPs and 35 were established in 2010. However no new appropriations have been enacted since and most CAPs have not received any new federal funding since 2012.[5] Pending additional federal funding, many CAPs remain operational, albeit at reduced levels.

**Broker** refers to a state-licensed professional who sells private health insurance to individuals and/or businesses. Brokers are sometimes called agents or producers. To sell non-group or small group health plans offered through a state Marketplace, brokers must register with the Marketplace annually, sign a participation agreement, and complete required training. Brokers who sell non-group policies through the Marketplace help consumers complete an application for financial assistance and explain coverage options. Brokers are paid a commission by the health insurance company offering the policy that the consumer selects. Typically insurers pay commissions when a policy is first issued and at renewal for at least several years. Brokers also offer ongoing services to consumers once they're covered, including help with post-enrollment questions and help buying other insurance products or financial services.

# Key Findings

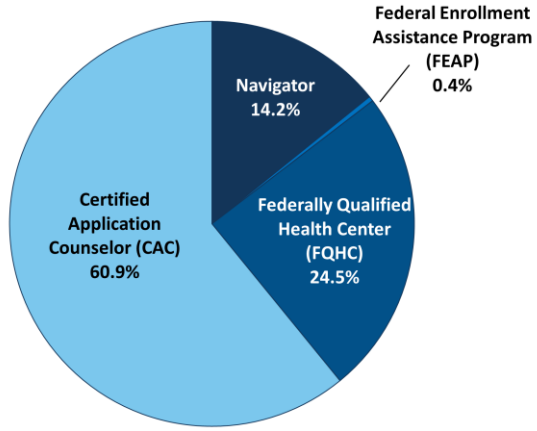
## Section 1: Characteristics of Assister Programs

**In all, more than 4,600 Marketplace Assister Programs were established to help consumers during the second Open Enrollment.** This total is based on Program data provided by all state and federal Marketplaces, and represents a 3% increase in the number of Programs established during the first Open Enrollment.

Once again, most Assister Programs that help people enroll in the Marketplace are not funded by Marketplaces. Navigators, which are funded directly by the Marketplace, comprise about 14% of total Programs. Assister Programs in FQHCs, primarily supported by HRSA grants, comprised another 25% and CAC Programs were 61%. Mostly CACs are voluntary Programs, supported by their sponsoring non-profit organizations, foundations, and other sources. Marketplaces are required to recognize and certify qualified CACs, but are not required to provide them financial support. (Figure 1) This distribution of Assister Program types is somewhat different from that during the first Open Enrollment period, and includes a larger proportion of CACs, largely because of a reclassification of Assister Program types in California.[6]

Figure 1

**Types of Assister Programs, 2015**




Total Number of Assister Programs = 4,680

NOTE: Data may not sum to 100% due to rounding.
SOURCE: Kaiser Family Foundation, *2015 Survey of Health Insurance Marketplace Assister Programs and Brokers*, August 2015.

**Most Assister Programs this year also helped consumers during the first Open Enrollment.** Over 90% of Programs indicated they operated during the first year. As a result, these Programs were more experienced. Prior to the first Open Enrollment, just two-thirds of Programs had experience helping consumers enroll in Medicaid and CHIP and only 16% of Programs had previously helped consumers enroll in private health insurance.

**Most Assister Programs served specific geographic or population-based communities.** Fourteen percent of all Programs operated in a statewide service area, the same proportion as in year one. However, the number of Navigator Programs operating statewide increased to 26% in year two (compared to 17% in year one). This could be attributable to funding requirements that encourage statewide coverage.

**Assister Programs varied in size and in the number of consumers they helped.** Most Programs have a small staff; 68% have five or fewer full-time-equivalent (FTE) staff, either paid or volunteer, while only 6% of Programs have more than 20 FTE staff. CACs were more likely to have small staff, with 71% of such Programs reporting five or fewer FTE staff, compared to 56% of Navigators. CACs were also more likely to rely primarily on volunteers (19% vs. 4% for other Program types.) These results are similar to year one.

Navigator and FQHC Assister Programs were more likely to report helping large numbers of consumers. This year 40% of Navigators and FQHCs said they helped more than 1,000 people during Open Enrollment. By contrast, 13% of CACs helped more than 1,000 people. This is similar to the distribution in year one. (Table 1)

**Table 1. Assister Programs by Size, Service Area, and Numbers of People Helped**

| Program Characteristics | All Assister Programs | Program Type | | |
|---|---|---|---|---|
| | | Navigator and FEAP | FQHC | CAC |
| **Worked during first Open Enrollment** | **91%** | **95%** | **96%** | **87%*^** |
| **Statewide vs. specific geographic service area** | | | | |
| Statewide | **14%** | **27%** | **10%*** | **13%*** |
| Specific area within state | **80%** | **68%** | **87%*** | **80%*^** |
| Other | **6%** | **5%** | **3%** | **7%^** |
| **Paid staff vs. volunteer** | | | | |
| Most/all volunteers | **13%** | **5%** | **3%** | **19%*^** |
| Most/all paid staff | **87%** | **95%** | **97%** | **81%*^** |
| **Number of full-time-equivalent staff and volunteers** | | | | |
| 5 or fewer | **68%** | **55%** | **67%*** | **71%*** |
| 6-10 | **17%** | **19%** | **22%** | **14%^** |
| 11-20 | **7%** | **11%** | **6%** | **6%*** |
| 21-50 | **5%** | **9%** | **3%*** | **5%** |
| More than 50 | **1%** | **4%** | **1%** | **1%** |
| Don't know/No answer | **2%** | **1%** | **1%** | **3%** |
| Mean FTE staff size | **6.8** | **12.2** | **6.1** | **5.8** |
| **Number of consumers helped during Open Enrollment** | | | | |
| 100 or fewer | **32%** | **14%** | **9%** | **45%*^** |
| 101-500 | **31%** | **28%** | **33%** | **30%** |
| 501-1,000 | **13%** | **17%** | **18%** | **10%*^** |
| 1,001-2,500 | **13%** | **22%** | **22%** | **8%*^** |
| 2,501-5,000 | **5%** | **8%** | **10%** | **2%*^** |
| More than 5,000 | **5%** | **10%** | **8%** | **3%*^** |
| Don't know/No answer | **1%** | **-** | **1%** | **2%** |
| Mean number of people helped per Program | **1,274** | **2,727** | **1,929** | **652** |
| **Portion of Consumers helped who were new to Marketplace vs. renewing** | | | | |
| **Most/nearly all renewing or changing** | **21%** | **18%** | **23%** | **21%** |
| **About half new/half renewing or changing** | **22%** | **26%** | **27%** | **20%** |
| **Most/nearly all new to Marketplace** | **53%** | **52%** | **46%** | **56%** |

*Significantly different from Navigator and FEAP at the 95% confidence level; ^Significantly different from FQHC at the 95% confidence level
NOTE: Numbers may not sum to 100% due to rounding.

**Assister Program budgets this year were mostly modest**. Twenty-nine percent of all Programs reported having an annual budget for consumer assistance of $50,000 or less. Slightly more (31%) had annual budgets between $50,000 and $500,000. Only 4% of Programs reported annual budgets larger than $500,000. CACs tended to have the smallest budgets compared to other types of Assister Programs. (Table 2)

Navigators were more likely to receive most of their funding from the Marketplace, while FQHCs relied more heavily on grants from HRSA. CACs were most likely to rely on re-programmed resources from their sponsoring organization or from other sources of private sector support.

**Table 2. Assister Program Budgets and Sources of Funding, FY 2014**

| | All Assister Programs | by Program Type | | |
|---|---|---|---|---|
| | | Navigator and FEAP | FQHC | CAC |
| **FY 2015 Program budget** | | | | |
| Up to $50,000 | 29% | 21% | 13%* | 38%*^ |
| $50,001 - $200,000 | 21% | 28% | 36% | 13%*^ |
| $200,001 - $500,000 | 10% | 21% | 12%* | 7%* |
| $500,001 - $1,000,000 | 2% | 10% | 1%* | 1%* |
| More than $1,000,000 | 2% | 4% | 1% | 2% |
| Don't know/No answer | 35% | 17% | 37% | 39% |
| **Programs receiving most (>50%) of budget from this funding source** | | | | |
| Grants or other direct payment from Marketplace | 13% | 42% | 3%* | 9%*^ |
| Grants from HRSA, other federal agency | 21% | 10% | 53%* | 11%^ |
| Grants or payments from other state agencies | 5% | 17% | 1%* | 3%*^ |
| Grants from private foundations | 2% | 2% | - | 5%* |
| Grants from other outside private sources | 1% | - | - | 2% |
| Funds re-programmed from sponsoring organization's own budget | 16% | 2% | 2% | 25%*^ |

*Significantly different from Navigator and FEAP estimate at the 95% confidence level; ^Significantly different from FQHC at the 95% confidence level
NOTE: Columns may not sum to 100% because not all Programs received a majority of funding from a single source.

**Assister Programs engaged in a range of activities during Open Enrollment.** Virtually all Programs provided eligibility and enrollment assistance, helping consumers apply for private health insurance and subsidies or for Medicaid and CHIP. Eighty percent of Programs also provided outreach and education to consumers. Beyond outreach and enrollment support, nearly 80% of Programs assisted consumers with post-enrollment questions and problems. Additionally, almost 6 in 10 helped consumers appeal Marketplace eligibility decisions, and new this year, more than 6 in 10 Programs helped consumers with ACA tax-related questions. (Table 3)

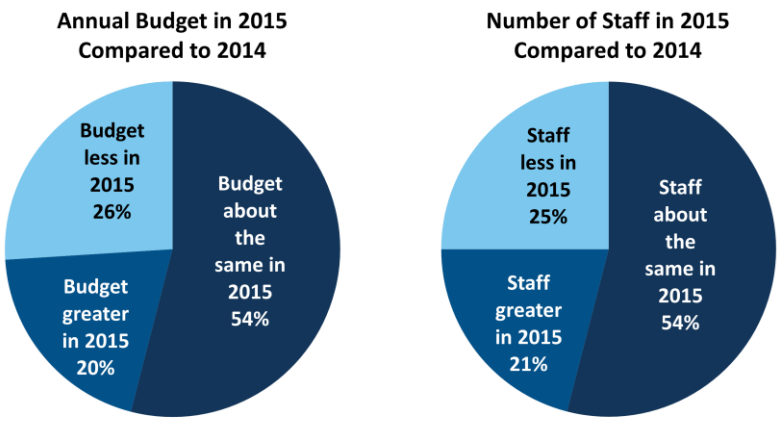
These percentages were similar to those reported last year; however, more Assister Programs this year reported helping consumers apply for exemptions from the individual mandate (61% this year vs. 50% last year).

| Table 3: Assistance Activities Conducted by Assister Programs | |
|---|---|
| **Activity** | **% Programs** |
| Help individuals apply for Medicaid/Children's Health Insurance Program | 90% |
| Help individuals compare private health insurance plan (QHP) options | 84% |
| Help individuals apply for premium tax credits and cost sharing subsidies | 81% |
| Outreach and public education to individuals and families | 80% |
| Help individuals with post-enrollment questions and problems (e.g., denied claims) | 79% |
| Help with ACA tax-related questions | 62% |
| Help individuals apply for exemptions from the individual responsibility requirement | 61% |
| Help individuals appeal eligibility determinations | 58% |
| Help other Assister Program staff resolve questions or problems for their clients | 58% |
| Outreach and public education to small businesses | 27% |

**Most Programs returned to help consumers for a second year, and almost half of those experienced changes in their staff size and budget.** This year 91% of responding Programs said they had also provided consumer assistance during the first Open Enrollment period. Roughly half said their budget and staff size in year two were about the same as in year one. About one-in five Programs grew while about one-in-four experienced declines in their staff or budget. (Figure 2)

Figure 2

**Changes in Annual Budgets and Number of Staff for Returning Assister Programs, 2015**




SOURCE: Kaiser Family Foundation, *2015 Survey of Health Insurance Marketplace Assister Programs and Brokers*, August 2015.

Staff continuity was strong in returning Programs. More than three-quarters of returning Programs said most or almost all of their staff from year one returned to help consumers in year two.

## Section 2: How Many Assisters Are There and How Many People Did They Help?

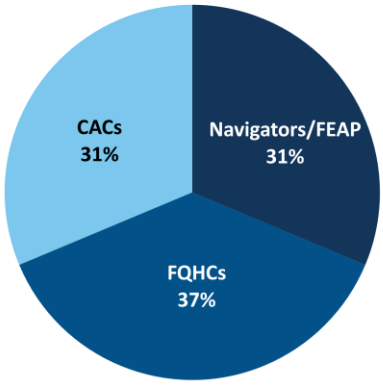
**An estimated 30,400 Assisters together helped more than 5.9 million people during the second Open Enrollment period.** Based on numbers of staff reported by survey respondents, we estimate all Programs combined employed at least 30,400 full-time equivalent (FTE) staff and volunteers to provide assistance across the country. This is roughly a 7% increase over the number of FTE Assisters in Year 1.

In addition, we estimate Assisters together helped more than 5.9 million people apply for coverage and financial assistance during the second Open Enrollment period.[7] Two things about this national estimate are noteworthy.

**Assister Programs that received Marketplace funding or HRSA funding helped most of the consumers.** Navigators and FEAPs, which comprise 15% of all Assister Programs nationwide, helped 31% of all consumers who received assistance this year. FQHCs, which account for 25% of all Assister Programs, assisted 37% of all consumers helped. By contrast, CACs, which make up 61% of all Assister Programs, assisted 31% of consumers helped. While the contribution of volunteer CAC Programs is substantial and not to be taken for granted, it was the formally funded Assister Programs – which had more resources and larger staff – that provided most of the help. (Figure 3)

Figure 3

**Distribution of Consumers Helped in Year Two, by Type of Assister Program, 2015**



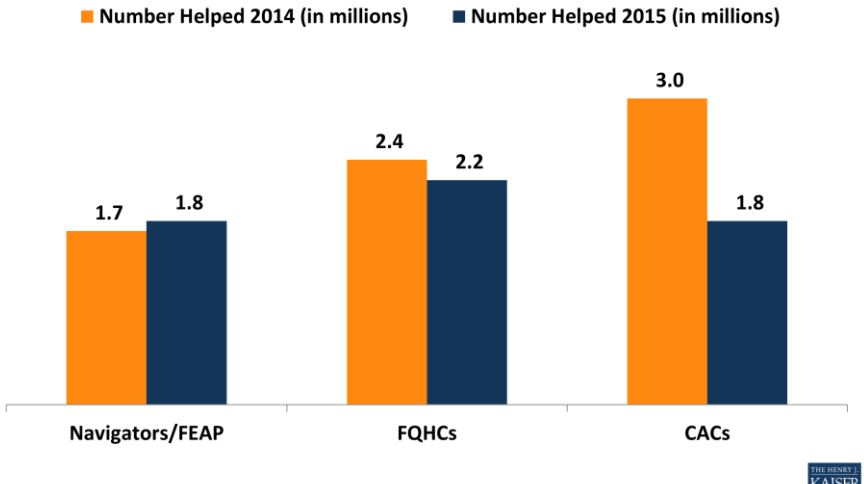

Total Number of Consumers Helped in 2015 = 5.9 million

NOTE: Data may not sum to 100% due to rounding.
SOURCE: Kaiser Family Foundation, *2015 Survey of Health Insurance Marketplace Assister Programs and Brokers*, August 2015.

**Returning Navigator and FQHC Programs helped about the same number of people this year, while the number helped by returning CACs declined sharply.** Based on data reported by returning Assister Programs, the estimated number of people helped this year declined by 19% overall compared to last year. Returning Programs report helping 7.1 million in year one vs. 5.8 million this year. However, CAC Programs, as a group, account for most of the decline. Returning Navigators and FQHCs, together, helped about the same number of people they did last year (4.1 million in year one vs. 4 million in year two), while the number of people helped by returning CACs fell 40 percent. (3 million in year one to 1.8 million in year two). (Figure 4)

Figure 4

## Number of People Helped by Returning Assister Programs, 2014 vs. 2015

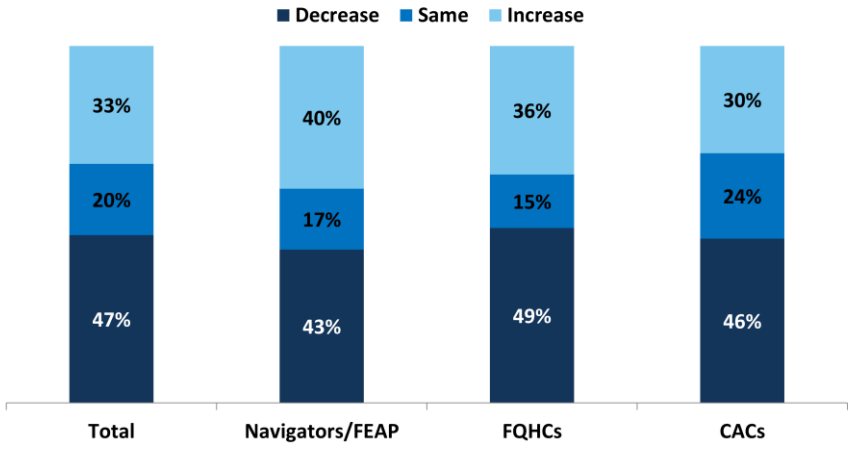



SOURCE: Kaiser Family Foundation, *2015 Survey of Health Insurance Marketplace Assister Programs and Brokers*, August 2015.

Even within Program types, however, there was also variation in the number of people helped in year two vs. year one. For example, 40% of returning Navigator Programs helped more people this year compared to last year, as did 30% of returning CACs. (Figure 5)

Figure 5

## Change in Caseload among Returning Assister Programs, 2015




SOURCE: Kaiser Family Foundation, *2015 Survey of Health Insurance Marketplace Assister Programs and Brokers*, August 2015.

A number of differences between the first and second Open Enrollment periods could have affected the numbers of consumers helped, such as:

- The second Open Enrollment period was half as long as the first one (3 months vs. 6 months)
- Most Marketplace websites worked better in the second year, and website difficulties led many consumers to seek in-person help in year one.

- About half of all enrollees during the second Open Enrollment period (4.2 million individuals) had first enrolled the year before and fewer of these consumers may have needed help; more than 2 million returning enrollees auto-renewed their health coverage and subsidies for 2015.
- On the other hand, people who were uninsured as the second Open Enrollment period began may have been harder to reach. First year Marketplace enrollees tended to be the most motivated and capable, while those who remained uninsured were likely less informed about the ACA and/or more burdened by language barriers, transportation problems, and other limitations.

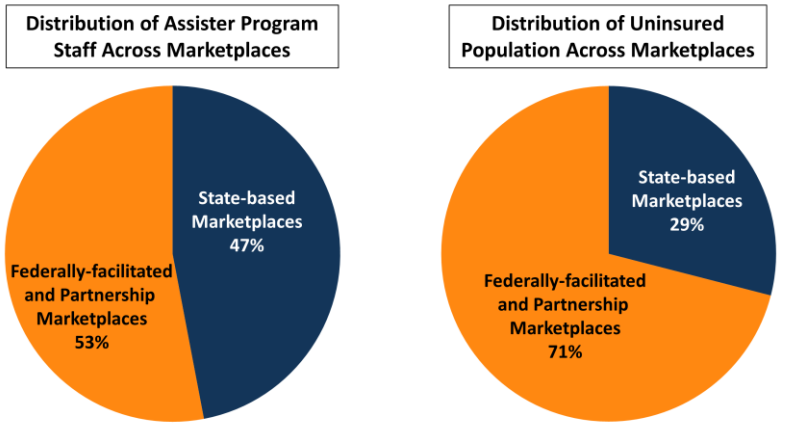
### National Estimates and Method Changes

Our national estimate of 5.9 million consumers helped by Assister Programs this year cannot be compared to our estimate of the total number helped during the first Open Enrollment Period due to changes in the way the question was asked. However, returning Assister Programs were asked separately this year to compare the number of people they helped during the first and second Open Enrollment periods. Estimates based on those responses are not impacted by the survey method changes. The responses by returning assisters suggest a 19 percent decline in number of people helped this year, compared to last year.

**Consumer Assistance resources continue to be unevenly distributed across Marketplaces.** Forty-seven percent of all Assisters nationwide worked in the 16 states and the District of Columbia with a SBM and 53% worked in the 34 states with a FFM or FPM, while 29% of the uninsured in 2014 resided in SBM states and 71% lived in FFM or FPM states. (Figure 6) As a result FFM and FPM states, on average, have fewer than half the number of Assisters per 10,000 uninsured compared to SBM states. A similar distribution was observed during year one. (Figure 7)

Figure 6

**Distribution of Assister Program Staff and Uninsured Population across Marketplaces, 2015**

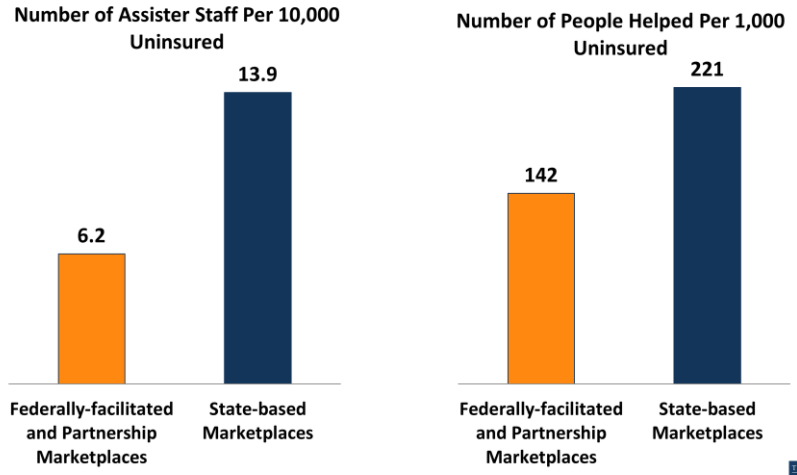



SOURCE: Kaiser Family Foundation, *2015 Survey of Health Insurance Marketplace Assister Programs and Brokers*, August 2015; KFF analysis of 2014 National Health Interview Survey.

**Relative to the number of uninsured, more people were helped in SBM states compared to FFM/FPM states.** Of the estimated 5.9 million people helped during the second Open Enrollment period almost 3.7 million, or 62%, lived in FFM/FPM states and almost 2.3 million, or 38%, were in SBM states. Expressed relative to the uninsured population, an estimated 142 people were helped per 1,000 uninsured in FFM/FPM states, and 221 were helped per 1,000 uninsured in SBM states. (Figure 7) This difference is likely driven in part by the disparity in Assister staff across SBM and FFM/FPM states. Another factor may be that a smaller share of FFM states had expanded Medicaid. The Medicaid coverage gap may have discouraged some poor uninsured from seeking help if they thought they would not qualify for coverage.

Figure 7

**Number of Assisters and People Helped Relative to the Uninsured Population across Marketplaces, 2015**




SOURCE: Kaiser Family Foundation, *2015 Survey of Health Insurance Marketplace Assister Programs and Brokers*, August 2015.

## Section 3: Why Did Consumers Seek Help?

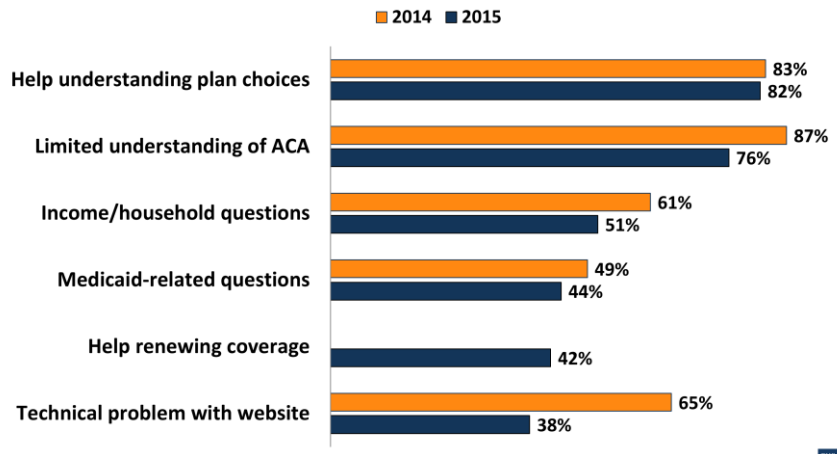
**Lack of understanding of the ACA and health insurance motivated many consumers to seek assistance.** Like last year, three-quarters of Assister Programs reported consumers sought help because they didn't understand the ACA, didn't understand health insurance, or lacked confidence to apply for coverage and financial assistance on their own. Overwhelmingly these were the top three reasons cited by Assister Programs last year and this year.

With millions of consumers returning to the Marketplace in year two to renew or change coverage, Assister Programs were less likely this year than last year to cite Marketplace website glitches as a major factor leading consumers to seek help. But in similar numbers to last year, Programs reported that consumers needed help answering Marketplace questions about their households and income, about their eligibility for Medicaid, and about other tax related questions. Also this year, for the first time, more than 40% of Programs said most consumers they served needed help renewing their coverage or updating their application for financial assistance for year two. (Figure 8)

Figure 8

**Reasons Consumers Sought Help, 2014 vs. 2015**

Share of Assister Programs reporting "most" or "all or nearly all" consumers sought help for the following reasons:



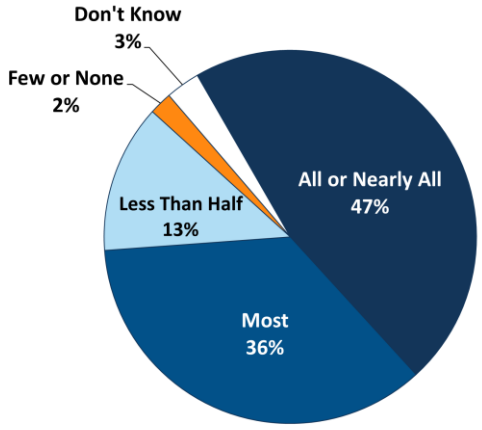

SOURCE: Kaiser Family Foundation, *2015 Survey of Health Insurance Marketplace Assister Programs and Brokers*, August 2015.

**Most who sought help were uninsured.** This year, 83% of Assister Programs reported that most to nearly all of the consumers they helped were uninsured at the time they sought assistance, slightly lower than the 89% of Programs last year reporting most to nearly all of the consumers they helped were uninsured. (Figure 9 and Appendix Table A1) This year for the first time some consumers sought help renewing coverage. Even so, most Assister Programs may remain focused primarily on outreach and assistance to uninsured individuals in year two. This may change in future years as more uninsured people get and keep health coverage.

Figure 9

## Consumers Seeking Help Who Were Uninsured, 2015

**Of the people your Assister Program helped with eligibility and enrollment in health coverage, roughly how many were uninsured at the time they sought assistance?**



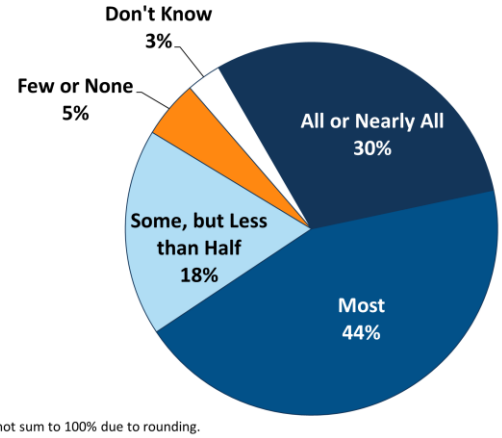

NOTE: Data may not sum to 100% due to rounding.
SOURCE: Kaiser Family Foundation, *2015 Survey of Health Insurance Marketplace Assister Programs and Brokers*, August 2015.

**Most who sought help also had limited health insurance literacy.** Unchanged from last year, 74% of Assister Programs said most to nearly all of their clients who shopped for or purchased private health plans needed help understanding basic insurance terms and concepts such as "deductible" and "in-network service." (Figure 10 and Appendix Table A1)

Figure 10

## Consumers Needing Help Understanding Basic Insurance Concepts, 2015

**Among your Program's clients who considered or purchased QHPs, how many needed help understanding basic insurance terms, such as "deductible" or "in-network service"?**

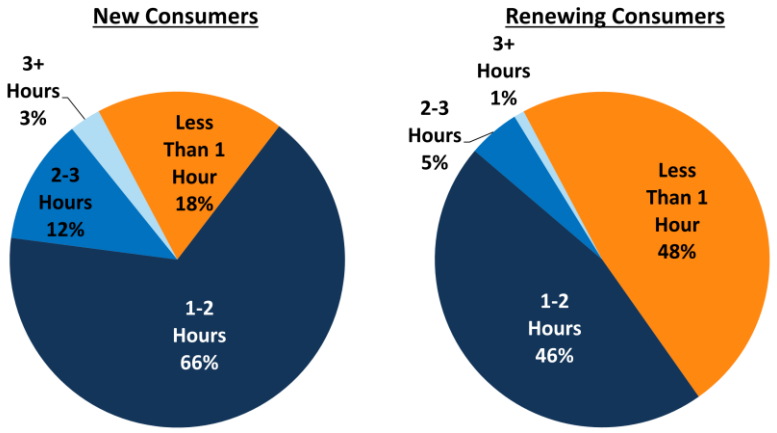



NOTE: Data may not sum to 100% due to rounding.
SOURCE: Kaiser Family Foundation, *2015 Survey of Health Insurance Marketplace Assister Programs and Brokers*, August 2015.

**Helping consumers renew coverage took less time.** When helping consumers who were returning to the Marketplace this year to renew or change coverage they had selected last year, the process was faster. Nearly half of Assister Programs said it took less than one hour, on average, to help consumers who were returning to the Marketplace. (Figure 11)

Figure 11

## Average Time Assister Programs Spent Helping New and Renewing Consumers, 2015




NOTE: Data may not sum to 100% due to rounding.
SOURCE: Kaiser Family Foundation, *2015 Survey of Health Insurance Marketplace Assister Programs and Brokers*, August 2015.

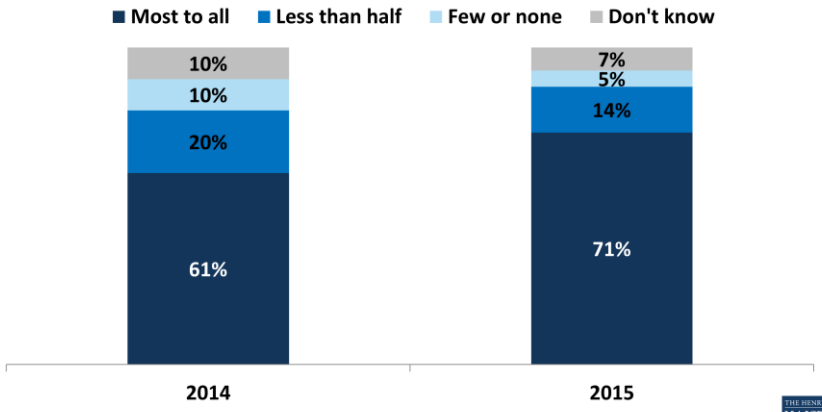
**Eligibility and enrollment assistance is time-intensive.** Similar to last year, about two-thirds of Assister Programs said it took one to two hours, on average, to help each consumer who was applying to the Marketplace for the first time. (Figure 11) However, there was a small increase in the number of Programs who said the average application took less than one hour, and a small decrease in the number reporting the average application took more than 2 hours. (Appendix Table A2) This uptick in appointments lasting less than an hour may reflect better functioning websites and more Assister experience using the application.

Appointment time efficiency gains appear to have been spent productively, with more Assisters able to complete the enrollment process with consumers this year, including selection of a health plan. Last year 61% of Assister Programs said they knew the plan choice outcome for most or nearly all consumers they helped. This year 71% said this was the case. (Figure 12)

Figure 12

## Consumers Completing the Enrollment Process, Including Selecting a Health Plan, 2014 vs. 2015

Of the people helped who were eligible to purchase a Marketplace QHP, for roughly how many did your Program know whether the person picked a plan?




NOTE: Data may not sum to 100% due to rounding.
SOURCE: Kaiser Family Foundation, *2015 Survey of Health Insurance Marketplace Assister Programs and Brokers*, August 2015.

## Help Between Open Enrollment Periods

**Assister Programs helped at least 630,000 consumers with special enrollment periods and at least 290,000 consumers report mid-year changes.** This year we asked returning Assister Programs about help they provided consumers outside of Open Enrollment periods. Most Programs were available throughout the year to help consumers who became eligible for special enrollment periods (SEPs or who needed to report other mid-year income or family changes to the Marketplace in order to update their application for subsidies.

On average, returning Programs each helped 183 consumers apply for SEPs last year. Forty-seven percent helped fewer than 50, but 24% of Programs helped more than 100. Navigator Programs and FQHCs helped more consumers with SEPs on average, compared to CACs. (Table 4) Nationwide, we estimate Assister Programs helped more than 630,000 consumer apply for SEPs in 2014.

**Table 4. Help with Special Enrollment Periods and Mid-Year Changes**

| | All Assister Programs | by Program Type | | |
|---|---|---|---|---|
| | | Navigator and FEAP | FQHC | CAC |
| **Number of People Helped with Special Enrollment Periods** | | | | |
| Up to 50 people | 47% | 27% | 33% | 60%*^ |
| 51-100 people | 15% | 19% | 19% | 12% |
| 101-500 people | 17% | 29% | 25% | 9%*^ |
| More than 500 people | 7% | 11% | 10% | 5%* |
| Don't know/No answer | 13% | 13% | 12% | 14% |
| **Number of People Helped with Mid-Year Changes** | | | | |
| Up to 50 people | 42% | 44% | 53% | 71%*^ |
| 51-100 people | 18% | 10% | 13% | 5%*^ |
| 101-500 people | 19% | 16% | 14% | 5%*^ |
| More than 500 people | 8% | 5% | 3% | 1% |
| Don't know/No answer | 13% | 25% | 17% | 18% |

*Significantly different from Navigator and FEAP estimate at the 95% confidence level; ^Significantly different from FQHC at the 95% confidence level
NOTE: Columns may not sum to 100% due to rounding.

Assister Programs also helped consumers report mid-year changes in their subsidy eligibility, though fewer consumers, overall, came in for this type of help. On average, each Program helped about 90 consumers report mid-year changes last year, although Navigator Programs and FQHCs helped more consumers report mid-year changes compared to CACs. (Table 4) Nationwide, we estimate Assister Programs helped more than 290,000 consumers report mid-year changes to the Marketplaces in 2014.

**Assister Programs provided post-enrollment help to nearly 800,000 consumers between the first and second Open Enrollment period.** During the 6-month period between Open Enrollments, nearly all returning Assister Programs also offered to help consumers with post-enrollment problems, though

they are not required to do so. Those Programs that did provide post-enrollment assistance, on average, helped about 250 consumers. Again, Navigator Programs and FQHCs helped more consumers with post-enrollment problems compared to CACs. (Table 5)

**Table 5. Help with Post-Enrollment Problems**

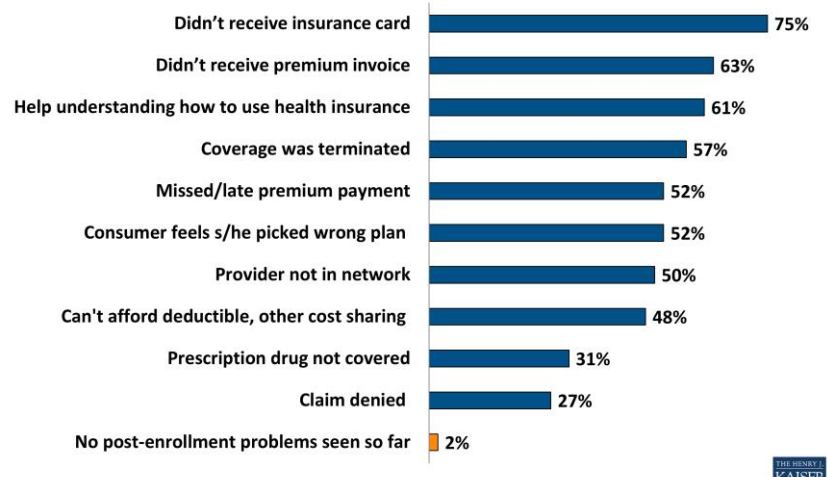
| | All Assister Programs | by Program Type | | |
|---|---|---|---|---|
| | | Navigator and FEAP | FQHC | CAC |
| **Number of People Helped with Special Enrollment Periods** | | | | |
| Up to 50 people | 42% | 29% | 32% | 51%*^ |
| 51-100 people | 18% | 14% | 19% | 19% |
| 101-500 people | 19% | 28% | 26% | 13%*^ |
| More than 500 people | 8% | 13% | 14% | 3%*^ |
| Don't know/No answer | 13% | 16% | 9% | 14% |

*Significantly different from Navigator and FEAP estimate at the 95% confidence level; ^Significantly different from FQHC at the 95% confidence level
NOTE: Columns may not sum to 100% due to rounding.

Consumers sought help with premium payment and invoicing problems, claims denials, and when their health providers were not in-network. Consumers also returned for help because they did not understand how to use their health coverage. (Figure 13) Most Assister Programs (69%) say they could help consumers successfully resolve post-enrollment problems most of the time; 27% said they succeeded just some of the time and 4% said not very often.

Figure 13

**Post-Enrollment Problems Assister Programs Encountered in 2015**



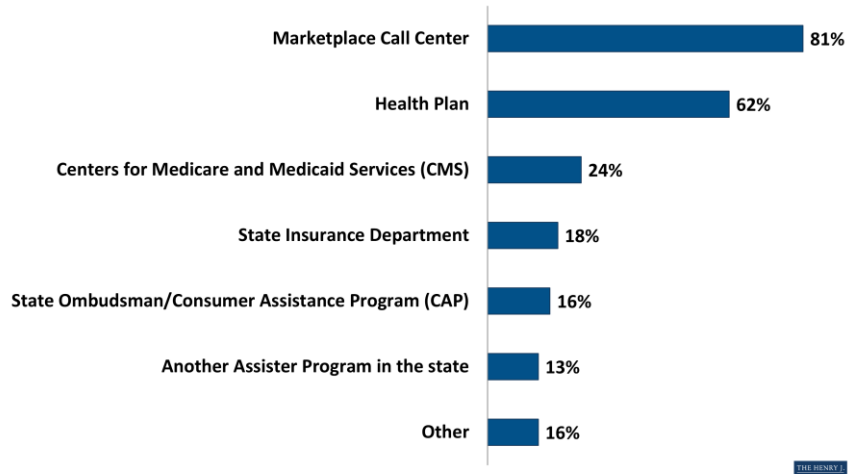

SOURCE: Kaiser Family Foundation, *2015 Survey of Health Insurance Marketplace Assister Programs and Brokers*, August 2015.

The ACA requires Navigators to refer consumers with post-enrollment problems to state Consumer Assistance Programs, or CAPs. However, federal funding for CAPs has not continued, and while many remain operational, Marketplace Assisters mostly refer consumers with post-enrollment problems elsewhere. When

asked where they refer consumers with post-enrollment problems they cannot resolve, only 16% of Assister Programs mention CAPs. Instead, like last year, Assisters mostly refer consumers to the Marketplace Call Center (81%) or back to their health plan (62%). (Figure 14)

Figure 14

**Where Assister Programs Refer Consumers with Post-Enrollment Problems, 2015**



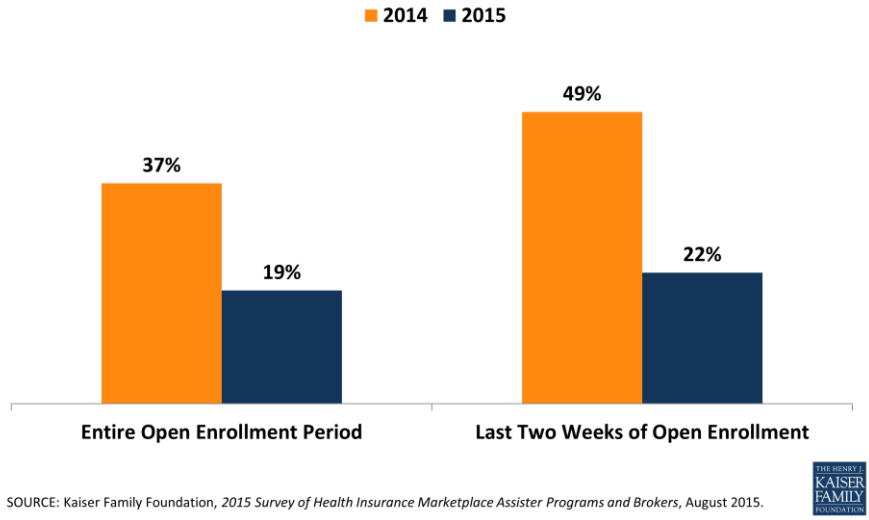

SOURCE: Kaiser Family Foundation, *2015 Survey of Health Insurance Marketplace Assister Programs and Brokers*, August 2015.

## SECTION 4: CHALLENGES FACING ASSISTER PROGRAMS

**Demand for consumer assistance sometimes exceeded capacity, though less so than last year.** For the second Open Enrollment period overall, 19% of Assister Programs said they could not help all who sought assistance. (Figure 15) In the final weeks of Open Enrollment, 22% of Programs said they had to turn at least some consumers away. This contrasts with 37% of Programs that were stretched beyond capacity overall during year one, and nearly half that had to turn away at least some consumers during the final weeks.

Figure 15

**Programs Reporting Demand for Consumer Assistance Exceeded Capacity, 2014 vs. 2015**




SOURCE: Kaiser Family Foundation, *2015 Survey of Health Insurance Marketplace Assister Programs and Brokers*, August 2015.

The shift in capacity relative to demand during the final weeks of Open Enrollment may be due to the fact that half of Marketplace enrollees this year were re-enrolling for a second year. In order to maintain continuous coverage on January 1, 2015, consumers had to re-enroll by mid-December. In addition, half of returning enrollees elected the auto-renewal option for 2015.

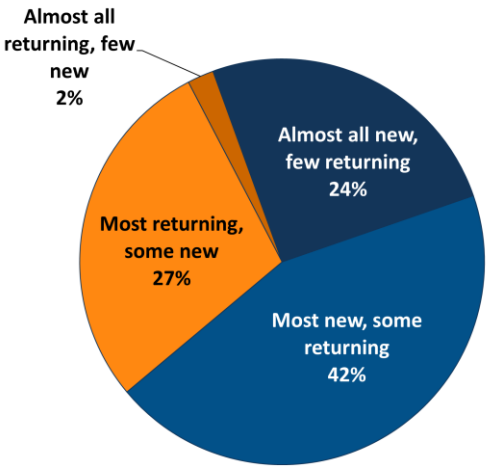
With respect to Marketplace consumer assistance capacity overall, it may be that capacity is coming more into alignment with the demand for help for many Assister Programs, though a significant number of Programs still are being asked for more help than they have capacity to provide.

**Client continuity was low.** Returning Assister Programs were asked approximately how many consumers they helped during the second Open Enrollment were returning clients they had helped the year before. Two-thirds of Programs responded that most to nearly all of the consumers helped this year were new. (Figure 16)

FQHCs were somewhat more likely to have an ongoing relationship with clients from year one. Over a third of FQHCs reported most clients they helped during the second open enrollment period were returning compared to less than a quarter of Navigators and CACs. In many Marketplaces, rules governing retention of identifiable personal information may have limited Programs' ability to follow up with consumers. Also, some consumers who needed help enrolling in year one may not have needed help in year two. In addition, many Programs still focus heavily on outreach and assistance to uninsured consumers. As more consumers gain coverage, the extent to which ongoing relationships develop between consumers and Assisters remains to be seen.

Figure 16

## Client Continuity Among Returning Assister Programs, 2015

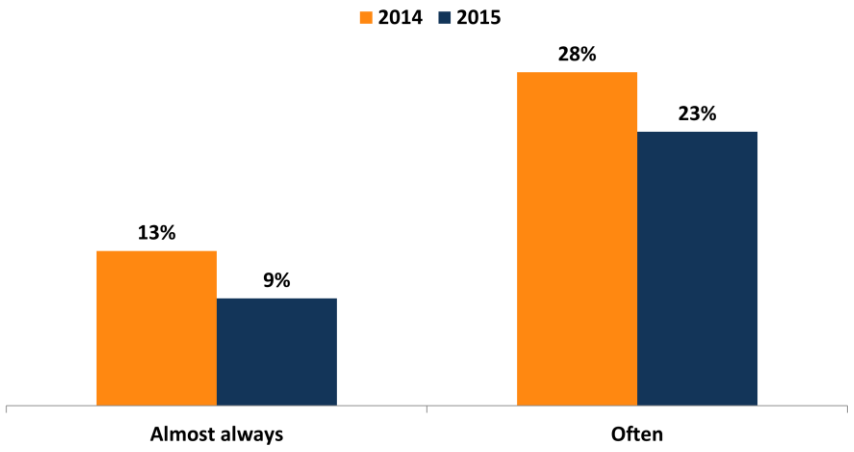



NOTE: Data may not sum to 100% due to rounding.
SOURCE: Kaiser Family Foundation, *2015 Survey of Health Insurance Marketplace Assister Programs and Brokers*, August 2015.

**Reported shortcomings in available health plan information hindered the ability of Assister Programs to help consumers evaluate QHPs in some cases.** Assister Programs continue to report that at least some of their clients who considered QHPs had questions about plans that weren't answered by information on the Marketplace website. However, the number of Programs indicating this was often or almost always the case declined to 31% this year, compared to 41% last year. (Figure 17)

Figure 17

## Assister Programs Reporting Consumers had Health Plan Questions Unanswered by Marketplace, 2014 vs. 2015



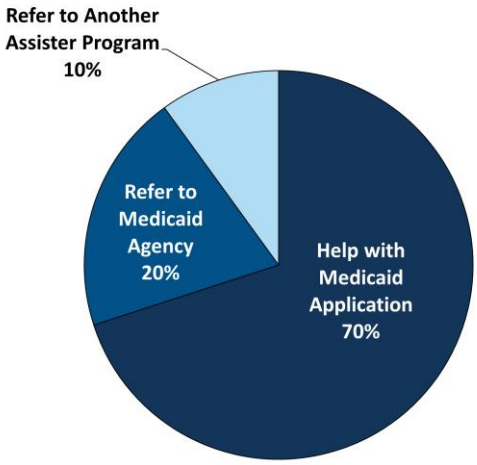

SOURCE: Kaiser Family Foundation, *2015 Survey of Health Insurance Marketplace Assister Programs and Brokers*, August 2015.

Respondents also report that insurers selling coverage in the Marketplace tend not to offer training on their health plans to Assister Programs; 74% of Programs say few or none of the insurers in their Marketplace do so.

**Most Assister Programs help clients apply for Medicaid and CHIP, but completing these applications often took multiple visits.** Under the ACA, Marketplaces must provide a single streamlined application process for individuals seeking financial assistance, whether through premium tax credits and cost sharing subsidies for QHPs or through Medicaid and CHIP. In many states so far, though, including most FFM states, Marketplace IT systems are not sufficiently integrated with Medicaid to seamlessly transfer applications and enroll eligible individuals in a single transaction. Instead, when the Marketplace assesses an individual is likely eligible for Medicaid or CHIP, that person must often make a separate application to the state Medicaid agency, re-entering information already submitted to the Marketplace.

Figure 18

**Assister Programs Helped Clients Apply for Medicaid/CHIP**

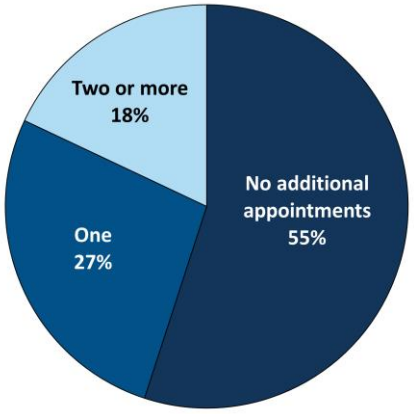



NOTE: Data may not sum to 100% due to rounding.
SOURCE: Kaiser Family Foundation, *2015 Survey of Health Insurance Marketplace Assister Programs and Brokers*, August 2015.

Most Programs said they will help consumers file a separate application for Medicaid or CHIP, while 30% refer consumers to another Assister Program or to apply on their own. (Figure 18) When Programs do help, 55% said the separate Medicaid application could usually be completed during the same appointment, while the rest said that it typically took multiple visits to help the client complete the transaction with Medicaid. (Figure 19)

Figure 19

**Number of Follow-up Appointments Required to Complete Medicaid Application, 2015**




NOTE: Data may not sum to 100% due to rounding.
SOURCE: Kaiser Family Foundation, *2015 Survey of Health Insurance Marketplace Assister Programs and Brokers*, August 2015.

**Call Center technical support was uneven.** Last year Programs reported that technical support from Marketplace call centers was not always effective. Last year Programs also listed types of consumer problems that could be especially difficult to resolve, including the need for translation services, immigration-related questions, tax-related questions, and help understanding QHP choices. This year, the survey asked Programs how often they turned to Call Centers for technical assistance when consumers presented with these types of problems and, when they did, how often they found Call Center technical assistance to be effective. (Table 6)

**Table 6. Necessity and Effectiveness of Technical Help from Marketplace For Assister Programs**

| | % That Sought Technical Help from Marketplace | | | % That Said Technical Help from Marketplace Was Effective | | |
|---|---|---|---|---|---|---|
| | Most/all of the time | Some of the time | Rarely/never | Most/all of the time | Some of the time | Rarely/never |
| Translation Services | 18% | 13% | 69% | 50% | 27% | 23% |
| Immigration Questions | 24% | 29% | 47% | 41% | 36% | 24% |
| Tax Questions | 18% | 35% | 47% | 45% | 37% | 19% |
| Questions About QHP Choices | 7% | 21% | 72% | 39% | 42% | 20% |

NOTE: Numbers may not sum to 100% due to rounding.

Assister Programs were more likely to seek help from the Call Center on cases involving immigration questions or tax related questions. Most Programs said they contacted the Call Center for help at least some of the time when faced with such cases. By contrast, 7 in 10 Assister Programs said they rarely if ever contacted the Call Center for help with translation services or questions about QHP choices.

When Programs did seek technical assistance, they said help from the Call Centers was uneven. Half of Assister Programs said Call Center help with translation was effective most to nearly all of the time. However, 39-45% of Programs ranked Call Center help as reliable on immigration, tax, and QHP questions. Between 19 and 24% of Programs said Call Centers rarely if ever provided effective help on these four topics.

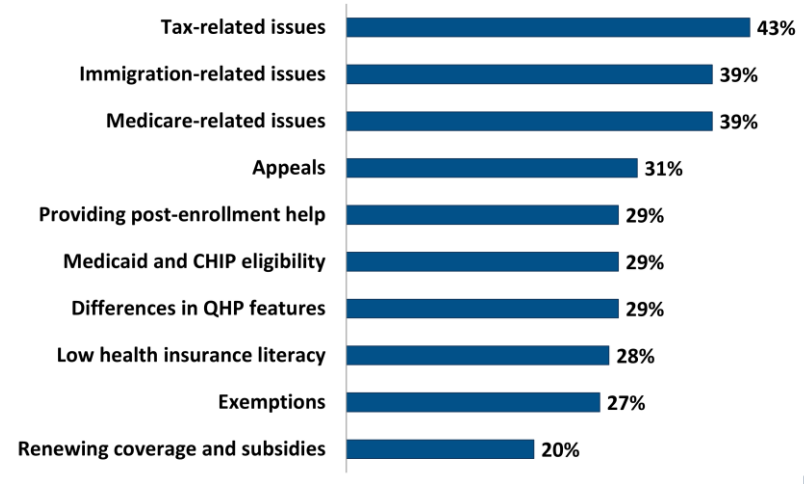
Last year, Assisters in some SBM states reported they had access to dedicated staff at the Marketplace Call Center who could expedite service and help resolve more complex questions. This year the FFM launched a dedicated help center for Assister Programs called the Assister Help Resource Center (AHRC). The new center was launched on a test basis in a few states after Open Enrollment began and was available for all FFM Assisters by the end of Open Enrollment. The AHRC was operated separately from the FFM Call Center and offered policy-related technical assistance (e.g., explaining eligibility rules for immigrants) but no application assistance (e.g., AHRC staff could not check on the status of an application or re-set a password). Survey respondents this year were not asked about the AHRC.

**Most Assister Programs reported they would like additional training on specific issues.** All Assister Program staff must complete initial training to be certified by Marketplaces, and returning staff had to be recertified to work in year two. In FFM and FPM states, Navigators were required to complete 30 hours of federal training, while CAC Assisters had to complete at least 5 hours of federal training. Depending on the applicable training curriculum, topics include eligibility standards for financial assistance, initial and renewal application procedures, and general standards for qualified health plans. In addition, during the year, Marketplaces may offer supplemental training. The FFM, for example, publishes a weekly newsletter for Assisters with updates on various topics. CMS also hosts periodic webinars to provide additional information during the year. Participation by Assisters is voluntary.

Nearly all Assister Programs (86%) indicated they would like additional training on a range of complex issues. Last year, more than 90% of Assister Programs indicated additional training would be helpful. Topics for which further training is desired are similar to those identified last year, except that further training on renewing health coverage and subsidies is new on the list this year. (Figure 20 and Appendix Table A3)

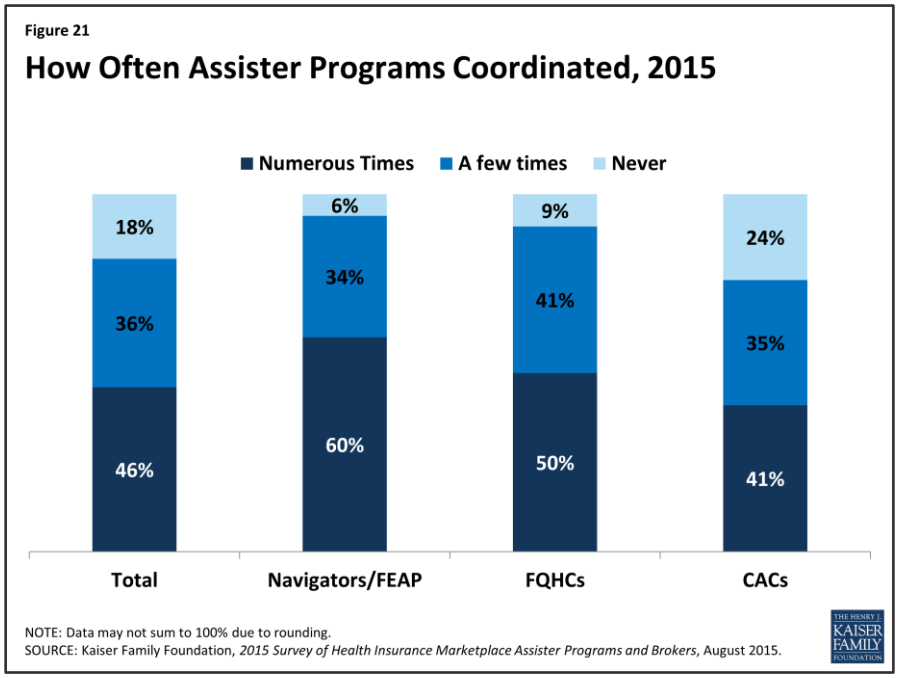
Figure 20

**Topics on Which Assister Programs Would Like Additional Training, 2015**




SOURCE: Kaiser Family Foundation, *2015 Survey of Health Insurance Marketplace Assister Programs and Brokers*, August 2015.

**While nearly all Assister Programs recognize the value of coordinating with other Programs on activities and to share best practices, a majority reported that they did not often coordinate with other Programs.** Like last year, Assister Programs strongly indicated that coordination with other Assister Programs improves effectiveness; 90% of Programs said coordination is somewhat or very important to operating effectively. But like last year, a majority of Programs say they seldom if ever coordinate with other Assister Programs. Just 46% said they coordinated often with other Programs. Navigators were most likely (60%) to report coordinating often with other Assister Programs, followed by FQHCs (50%). (Figure 21)




Coordination was most often initiated by Assisters themselves or by an outside third party. Nine percent of Programs say the Marketplace facilitated coordination, though in SBM states, it was 19%. When Marketplaces did help Programs coordinate, this was most often the case for Navigators. (Table 7) Most FQHCs receive coordinating help from their state Primary Care Associations, which receive separate HRSA grants to support FQHC Assisters.

**Table 7. Who Initiates Coordination Among Assister Programs**

| | All Programs | Program Type | | | Marketplace Type | |
|---|---|---|---|---|---|---|
| | | Navigator/ FEAP | FQHCs | CACs | FFM/FPM | SBM |
| Marketplace | 9% | 22% | 7%* | 7%* | 3% | 19%** |
| Other third party | 33% | 28% | 43%* | 29%^ | 31% | 34% |
| Programs coordinate on their own | 64% | 73% | 61%* | 63%* | 71% | 55%** |

*Significantly different from Navigator and FEAP at the 95% confidence level; ^Significantly different from FQHC at the 95% confidence level
**Significantly different from FFM/FPM at the 95% confidence level.

## Section 5: Consumer Assistance by Health Insurance Brokers

For the first time this year, the survey included health insurance brokers who helped consumers apply for non-group coverage in the Marketplace. Most, though not all state Marketplaces provided contact information for their certified brokers. As a result, survey findings are generalizable to most states but may not reflect experiences unique to some states.

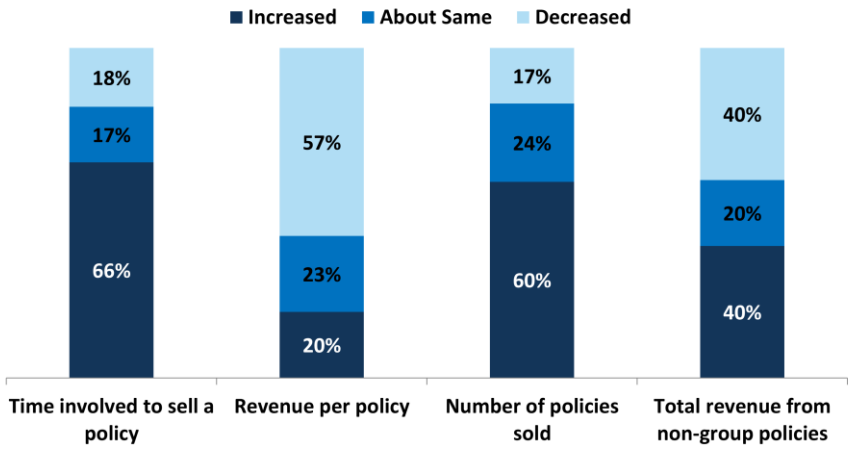
### Characteristics of Marketplace brokers

The vast majority (86%) of brokers who sold non-group coverage in the Marketplace this year had done so during the first Open Enrollment period and prior to 2014. Similar to Assistance Programs, 80% of returning brokers said they thought this year's Open Enrollment went better than the first.

The opening of ACA Marketplaces in January 2014 changed the business of selling non-group health insurance for most brokers. Most say the time involved in selling a private policy has increased relative to pre-ACA days (66%), and revenue earned per policy has decreased (57%); but most also say they sell more non-group policies overall than they did pre-ACA (60%). Forty percent of brokers say their overall revenue from the sale of non-group policies has increased, 40% say overall revenue has decreased, and 20% say it is about the same. (Figure 22)

Figure 22

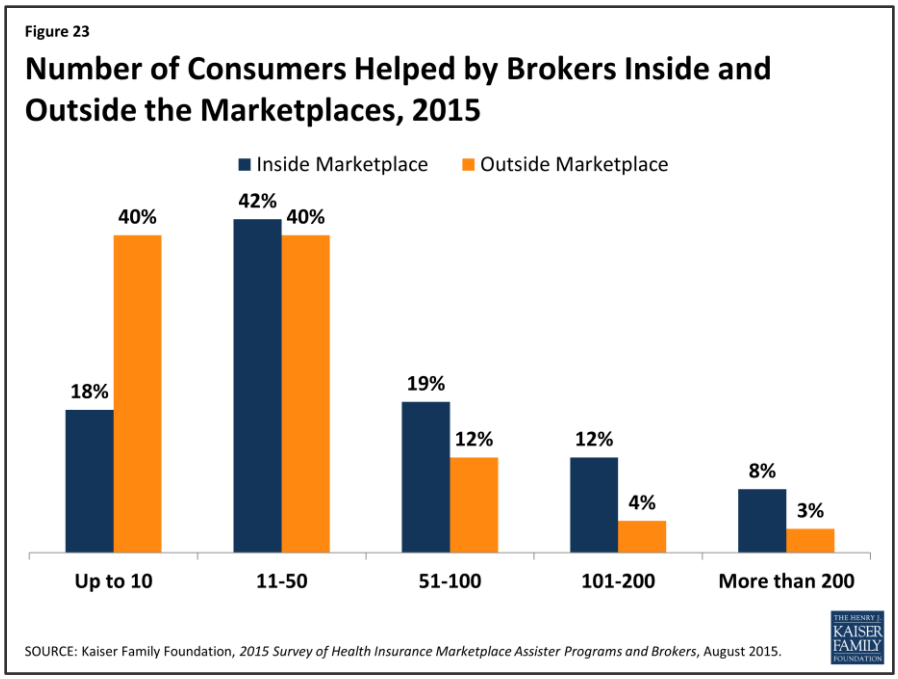
**Changes in Broker Work and Revenues from Sale of Non-group Policies since ACA Implementation**




NOTE: Data may not sum to 100% due to rounding.
SOURCE: Kaiser Family Foundation, *2015 Survey of Health Insurance Marketplace Assister Programs and Brokers*, August 2015.

Most brokers who sold Marketplace coverage (79%) also sold policies outside of the Marketplace. On average, brokers report helping about 140 consumers, both in and outside of the Marketplace, with eligibility and enrollment during the second Open Enrollment period. On average, brokers helped almost twice as many clients apply for coverage through the Marketplace (91) compared to outside of the Marketplace (49).

Some brokers were busier than others. Sixty percent said they helped up to 50 Marketplace consumers during this Open Enrollment period, while 20% of brokers said they helped more than 100. (Figure 23) Returning brokers, on average, helped about 8% fewer consumers this year compared to year one.




## Comparing Activities of Brokers and Assister Programs

Brokers generally engaged in similar consumer assistance activities as Assister Programs, but with emphasis on different services. For example, the vast majority of both brokers and Assister Programs said they help consumers compare and select QHPs, apply for premium tax credits, and resolve post-enrollment problems. But, compared to Assister Programs, brokers were less likely to engage in outreach and public education activities (33% vs 80%) and less likely to help consumers appeal Marketplace eligibility decisions (39% vs 58%). Compared to Assister Programs brokers were more likely to help small businesses select coverage (34% vs 9%).

Brokers were also less likely, compared to Assister Programs to help individuals apply for Medicaid and CHIP (49% vs 90%). Brokers who said they helped consumers with Medicaid applications were more likely to be from SBM states, where Marketplace websites are better integrated with Medicaid. However, when Marketplaces determined that consumers should complete a separate Medicaid application, brokers helped them do this less often than did Assister Programs. (13% vs. 69%)

Similar to Assister Programs, most brokers said, on average it took about one-to-two hours to help each client that was applying to the Marketplace for the first time, and about one hour to help clients who were returning to renew or change their Marketplace coverage.

Also similar to Assister Programs, most brokers said they would like to receive additional training on a range of topics, including tax related issues, Marketplace appeals and renewal procedures, Medicare, and Medicaid. And, similar to Assister Programs, brokers report that when they did need to seek technical assistance from Marketplace Call Centers, help was often inconsistent or ineffective. (Table 8)

| Table 8. Use and Effectiveness of Technical Help from Marketplace For Brokers | | | | | | |
|---|---|---|---|---|---|---|
| | % That Sought Technical Help from Marketplace | | | % That Said Technical Help from Marketplace Was Effective | | |
| | Most/all of the time | Some of the time | Rarely/never | Most/all of the time | Some of the time | Rarely/never |
| Translation Services | 14% | 10% | 76% | 48% | 20% | 32% |
| Immigration Questions | 27% | 13% | 60% | 47% | 28% | 25% |
| Tax Questions | 16% | 25% | 58% | 37% | 30% | 33% |
| Questions About QHP Choices | 4% | 6% | 89% | 44% | 25% | 32% |

NOTE: Numbers may not sum to 100% due to rounding

## Comparing Clients of Brokers and Assister Programs

Similar to Assister Programs, brokers overwhelmingly said the consumers they helped had limited understanding of the ACA and limited health insurance literacy. In other respects, though, brokers served a somewhat different clientele. For example,

- 82% of brokers said few or none of their clients needed language translation help, compared to 53% of Assister Programs
- 9% of brokers said most or all of their clients lacked internet at home, compared to 35% of Assister Programs
- 49% of brokers said they helped Latino clients, compared to 77% of Assister Programs
- 50% of brokers said most or nearly all clients they served were uninsured when they sought help, compared to 83% of Assister Programs
- 8% of brokers said most or nearly all clients had income low enough to qualify for Medicaid, compared to 50% of Assister Programs.

Brokers also reported higher rates of client continuity and were more likely than Assister Programs (47% vs 29%) to say most of the consumers they helped this year were people whom they had also helped during the first Open Enrollment period.

# Discussion

Last year, we reported the establishment of new consumer assistance resources under the ACA was a significant new development in the health coverage system. The ACA enabled millions of new consumers to enroll in coverage and created a new process for applying for coverage and financial assistance. Last year, we reported the new consumer assistance infrastructure faced many challenges, including inexperience and IT problems. This year most Programs are more seasoned and websites worked better. But challenges remain.

Returning Assister Programs helped 19% fewer people during the second Open Enrollment period. Returning Navigator and FQHC Programs (supported by Marketplace and HRSA grants, respectively) helped about the same number of consumers this year; voluntary CAC Programs experienced most of the decline in people helped. Two years do not make a trend. But because the level of consumer assistance provided this year was more sustained in grant funded programs compared to volunteer programs, this suggests that continued investment in Marketplace consumer assistance would make a difference. So far, though, a minority (27%) of Assister Programs overall say they are very certain funding will be available to support their work next year.

Programs also suggest other changes that could improve their efficiency and effectiveness. Strengthening the technical assistance offered by Marketplace Call Centers, and fully integrating Marketplace and Medicaid websites are steps that could streamline the enrollment process.

Facilitating coordination between Assister Programs is something else Marketplaces could undertake to strengthen consumer assistance. Returning Programs that coordinated often with other Assister Programs were more likely to increase the number of people they helped this year. In some states, so-called super Navigators have been designated (formally by the Marketplace or informally) to promote coordination, centralize training and mentor new Assisters, facilitate scheduling and referrals, and help on complex cases.

Further capacity building may also still be important, though capacity constraints were less severe than in year one. One-in-five Assister Programs this year said they could not help all consumers who needed it. Because voluntary CAC Programs continue to provide a significant portion of all consumer assistance, Marketplaces could consider targeting additional financial support or coordination to at least some of these Programs, as well.

For a second year, enrollment assistance was time intensive. This year more Programs were able to complete the process through consumer selection of a health plan. But plan comparison and selection continued to pose challenges. Help comparing plans is still one of the leading reasons why consumers seek in-person help. Assisters still report many consumers have questions about plan choices that were not answered by information on Marketplace websites. Low health insurance literacy among consumers also persists. Because consumers may be faced with dozens of Marketplace plan choices, improving this process will be challenging. The FFM and some state Marketplaces are working to gradually improve the quality of health plan information and to develop new plan comparison tools for consumers in the future. But consumers will likely need a substantial amount of in person help, in addition, for years to come.

Outside of Open Enrollment, many Assister Programs remained busy. During the 6-month period between enrollment periods, Assister Programs helped nearly 300,000 people report mid-year changes and more than 600,000 people apply for special enrollment periods (SEP). Over the same period Assister Programs also

helped nearly 800,000 individuals with post-enrollment problems. The ACA provided for state-based ombudsman programs (CAPs) to help with post enrollment problems and requires Navigators to refer consumers to CAPs for this kind of help. However this part of the ACA consumer assistance infrastructure is the least developed. CAPs were established in most states in 2010, but most have not received any new federal funding since 2012.

Brokers also continue their traditional role helping consumers in the non-group market, and are an important source of assistance for consumers seeking marketplace coverage. Most in this space today sold non-group coverage prior to the ACA. Most say it now takes more time to sell a non-group policy and the per-policy commission is lower. But most also say they are earning as much or more in total non-group revenue today compared to pre-2014, though a substantial minority also report earning less. Brokers also continue to help consumers buy coverage outside of the Marketplace. On average, brokers sell one policy outside for every two Marketplace policies they sell.

Brokers and Assister Programs engage in many of the same activities, though brokers are less likely to help consumers apply for Medicaid and more likely to help small businesses apply for small group plans. Brokers also appear less likely, compared to Assister Programs, to help some other of the most vulnerable consumers, including those who lack internet at home and those who need translation assistance. The implication for Marketplaces would seem to be that brokers and Assister Programs are not interchangeable. To ensure that all consumers who need help receive it, both types of professionals will need to continue their key roles.

# Methods

The Kaiser Family Foundation 2015 Survey of Health Insurance Marketplace Assister Programs and Brokers was designed and analyzed by KFF researchers and administered by Davis Research. This nationwide survey was conducted through an online questionnaire from March 31, 2015 through May 3, 2015.

## Assister Programs

To recruit Assister Program survey participants, we asked officials CMS and from States operating SBM or FPM Marketplaces to provide contact information for the directors of their certified Assister Programs. In addition, we requested contact information for the directors of enrollment assistance activities in each of the FQHCs from HRSA. All Assister Programs received an email with a link to the survey inviting the director to participate. In the event the person receiving the survey was not the appropriate person to complete it, they were asked to provide the contact name and email for the appropriate person within their organization.

To analyze results, we assigned Assister Programs to one of four types based on their primary source of funding. The first type, Navigators, were those identified by Marketplace officials contracted with and received grant funding directly from the Marketplace. Of note, last year we distinguished between Marketplace-funded Programs that were supported with Section 1311 grant funds – called In Person Assisters (IPAs) – and those that received other Marketplace funding – Navigators. Because Section 1311 grant funds were discontinued, this year we categorized as Navigators all Assister Programs that received direct grant funding from a Marketplace. The second type, FEAP, were those identified by CMS as contractors that operate in certain FFM states and that otherwise act as Navigators. We tracked FEAP responses separately in the survey, but for most data analysis presented in this report we combined responses of FEAPs and Navigators. The third type, FQHCs, were those that received grant funding from HRSA to provide enrollment assistance. We identified FQHCs using the contact list provided by HRSA. A small percentage of FQHC Programs receive both HRSA grants and Marketplace Navigator grant funding; these were categorized as Navigators for our analysis. All other Assister Programs certified to provide assistance in Marketplaces were designated as CACs.

A total of 4,680 Programs were invited to participate in the study, and 713 Programs responded and were included (for a response rate of 15%). Because response rates varied by Program type, data were weighted to reflect the distribution in the initial sample by Program type and Marketplace type (FFM, FPM, or SBM). Weighted and unweighted proportions of the final sample by Program type are shown in the table below.

| | Unweighted % of total | Weighted % of total |
|---|---|---|
| FFM CAC | 23% | 34% |
| FFM FQHC | 15% | 14% |
| FFM Navigator/FEAP | 7% | 2% |
| FPM CAC | 3% | 4% |
| FPM FQHC | 2% | 2% |
| FPM Navigator/FEAP | 3% | 2% |
| SBM CAC | 18% | 22% |
| SBM FQHC | 11% | 8% |
| SBM Navigator/FEAP | 18% | 11% |

## Nationwide Estimates

Using responses provided by Assister Programs in the study, we were able to estimate the number of Assister Program staff and the number of consumers they helped with eligibility and enrollment in Medicaid/CHIP and Qualified Health Plans during the second Open Enrollment period nationwide, by extrapolating response data to the national level. Survey participants were asked to provide the number of full-time equivalent Assisters in their Program and the number of consumers helped. Respondents who did not provide a numeric value for the number of consumers helped were asked to estimate a number using a range of options. In making our calculation, we used the midpoint value for responses that provided a range of numbers of consumers helped. Non-responses were imputed based on the type of Assister Program.

We also surveyed the work of Assister Programs outside of Open Enrollment as they helped people apply for Special Enrollment Periods, report mid-year changes to the Marketplace, and resolve post-enrollment problems. Using response data provided by returning Assister Programs, we were able to estimate the number of people nationally who received help from Assister Programs between the first and second Open Enrollment periods with each of these types of issues.

## Brokers

To recruit brokers in the Federally-Facilitated Marketplace (FFM) states, we obtained contact information from a comprehensive file of brokers in the FFM states, made publicly available through HealthCare.gov.[8] To obtain broker contact information from the SBM and FPM states, we asked Marketplaces to provide contact information, and when that was not provided, compiled contact information that was publicly available on Marketplace websites. As we estimate that there are tens of thousands of brokers selling non-group Marketplace policies nationwide, we drew a sample of 9,700 brokers based on their distribution by Marketplace type (FFM, FPM, or SBM). Our general sampling rule was to randomly select 10% of all contacts in each state; we oversampled in ten states where we had fewer than 500 contacts to begin with. Because we did not have a complete sample of Marketplace brokers in all states, we were not able to compute national estimates of the numbers of consumers helped by brokers.

Out of the 9,700 brokers who were invited to participate in the study, 662 responded and were included (for a response rate of 7%).

## Toplines and Margin of Sampling Error

Survey toplines with overall frequencies of both Assister Programs and Brokers for all survey questions are available at http://kff.org/health-reform/report/2015-survey-of-health-insurance-marketplace-assister-programs-and-brokers.

The sample size and margin of sampling error (MOSE) for the total sample and key subgroups of Assister Programs are shown in the table below. All statistical tests of significance account for the effect of weighting.

| Group | N (unweighted) | MOSE |
|---|---|---|
| Total | 713 | +/-4 percentage points |
| CAC | 311 | +/-6 percentage points |
| FQHC | 202 | +/-7 percentage points |
| Navigator and FEAP | 200 | +/-7 percentage points |

| Brokers | N (unweighted) | MOSE |
|---|---|---|
| Total | 662 | +/-4 percentage points |

# Appendix: Additional Tables

**Table A1: Characteristics of Consumers Helped by Assister Programs, 2014 vs. 2015**

| Clients who were uninsured at time of assistance | 2014 | 2015 |
|---|---|---|
| All or nearly all | 46% | 36%* |
| Most | 43% | 47% |
| Some, but less than half | 7% | 13%* |
| Few or none | 2% | 2% |
| Don't know | 18% | 19% |
| **Clients determined eligible for Medicaid or CHIP** | | |
| All or nearly all | 6% | 13%* |
| Most | 38% | 37% |
| Some, but less than half | 33% | 29% |
| Few or none | 16% | 19% |
| Don't know | 6% | 3% |
| **Clients falling into the coverage gap** | | |
| All or nearly all | 1% | 4%* |
| Most | 12% | 11% |
| Some, but less than half | 36% | 36% |
| Few or none | 41% | 44% |
| Don't know | 10% | 6% |
| **Clients determined eligible for premium tax credits** | | |
| All or nearly all | 8% | 11%* |
| Most | 38% | 40% |
| Some, but less than half | 40% | 35% |
| Few or none | 10% | 11% |
| Don't know | 5% | 4% |
| **Clients eligible for Marketplace coverage without premium tax credits** | | |
| All or nearly all | 0% | 1% |
| Most | 3% | 5%* |
| Some, but less than half | 26% | 26% |
| Few or none | 65% | 65% |
| Don't know | 5% | 3% |
| **Clients needing help understanding basic insurance concepts** | | |
| All or nearly all | 33% | 30% |
| Most | 41% | 44% |
| Some, but less than half | 19% | 18% |
| Few or none | 5% | 5% |
| Don't know | 2% | 3% |

*Significantly different from 2014 estimate at the 95% confidence level
NOTE: Numbers may not sum to 100% due to rounding

| Table A2: Average Time Assister Programs Spent Helping Each Client New to Marketplace | | |
|---|---|---|
| | 2014 | 2015 |
| Less than one hour | 13% | 18%* |
| One hour up to two hours | 64% | 66% |
| Two hours up to three hours | 18% | 12%* |
| Three hours up to four hours | 3% | 2% |
| Four hours or longer | 2% | 1% |
| Mean | 1.7 hours | 1.5 hours* |
| Median | 1.6 hours | 1.5 hours |

*Significantly different from 2014 estimate at the 95% confidence level
NOTE: Numbers may not sum to 100% due to rounding

| Table A3: Topics on Which Assister Programs Would Like Additional Training, 2014 vs. 2015 | | |
|---|---|---|
| | 2014 | 2015 |
| Tax-related Issues | 41% | 43% |
| Immigration-related Issues | 39% | 39% |
| Medicare-related Issues | 34% | 33% |
| Appeals | 36% | 31%* |
| Providing Post-enrollment Help | 41% | 29%* |
| Medicaid and CHIP Eligibility | 35% | 29%* |
| Differences in QHP Features | 39% | 29%* |
| Low Health Insurance Literacy | 34% | 28%* |
| Exemptions | 33% | 27%* |
| Renewing Coverage and Subsidies | - | 20%* |
| Eligibility for Premium Tax Credits | 32% | 20%* |
| Special Enrollment Periods | 27% | 15%* |

*Significantly different from 2014 estimate at the 95% confidence level

# Endnotes

[1] Center for Consumer Information and Insurance Oversight, "Navigator Grant Recipients for States with Federally-facilitated or State Partnership Marketplace, " available at http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Navigator-Grantee-Summaries-UPDATED-05-05-15.pdf.

[2] The 14 SBM states in year two were California, Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, New York, Rhode Island, Vermont and Washington. The 4 consumer assistance FPM states were Delaware, Illinois, New Hampshire and West Virginia. Arkansas has been approved for status as a consumer assistance FPM in year one, but ceased providing state support for consumer assistance in year two and so was included with FFM states for this analysis.

[3] Information on funding for In-person Assisters and Navigators provided by state-based marketplaces collected by KFF staff through information available on state websites and through conversations with state officials.

[4] During the second Open Enrollment period, FEAPs operated in Arizona, Florida, Georgia, Indiana, Louisiana, North Carolina, New Jersey, Ohio, Pennsylvania, and Texas.

[5] Twelve CAP programs received limited supplemental grants for FY 2015: California, Connecticut, District of Columbia, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, New York, North Carolina, and Vermont.

[6] In year one, California provided for a type of Assister Program called Certified Enrollment Counselors (CECs) that were paid by the Marketplace on a per-enrollment basis. Subsequently, federal regulations prohibited Marketplaces from funding Navigators on a per-enrollment basis. For year two, California established a new Navigator Program, funded through Marketplace grants. The CEC program continues in California, though not all CECs receive Marketplace reimbursement. During the first two years, there were between 600 and 700 CEC Programs in California. During the first year of this survey, all CECs were classified as Navigator/In-Person Assister Programs. During the second year of this survey, CECs were included in the CAC classification. This change in classification accounts for roughly a 10 percentage point change, from year 1 to year 2, in the proportion of total Assister Programs that are CACs.

[7] Estimates were derived by extrapolating survey responses (on how many staff worked for Assister Programs and hope many people were helped) to data on the number of Assister Programs nationwide collected from the Marketplaces.

[8] https://localhelp.healthcare.gov/

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The COMMONWEALTH FUND

THE HENRY J. KAISER FAMILY FOUNDATION

# Primary Care Providers' Views of Recent Trends in Health Care Delivery and Payment

## Findings from the Commonwealth Fund/Kaiser Family Foundation 2015 National Survey of Primary Care Providers

**Abstract** A new survey from The Commonwealth Fund and The Kaiser Family Foundation asked primary care providers—physicians, nurse practitioners, and physician assistants—about their experiences with and reactions to recent changes in health care delivery and payment. Providers' views are generally positive regarding the impact of health information technology on quality of care, but they are more divided on the increased use of medical homes and accountable care organizations. Overall, providers are more negative about the increased reliance on quality metrics to assess their performance and about financial penalties. Many physicians expressed frustration with the speed and administrative burden of Medicaid and Medicare payments. An earlier brief focused on providers' experiences under the ACA's coverage expansions and their opinions about the law.

## OVERVIEW

In recent years, the U.S. primary care delivery system has experienced many changes in the way health care is organized, delivered, and financed. Some of these changes have been strengthened or accelerated by the Affordable Care Act (ACA). For instance, there has been an increased use of health information technology, a move toward team-based care and using nonphysician clinicians, an effort to better coordinate care through medical homes and accountable care organizations, and the introduction of financial incentives and quality metrics to determine how providers are paid.

Using data from the Commonwealth Fund/Kaiser Family Foundation 2015 National Survey of Primary Care Providers, this brief examines providers' opinions about the changes in primary care payment and health care delivery. Between January 5 and March 30, 2015, a nationally representative sample of 1,624 primary care physicians and a separate sample of 525 midlevel clinicians (i.e., nurse practitioners and physician assistants) working in primary care practices were surveyed online and by mail.

The survey finds that providers' experiences with new models of care and changes to the health care system are varied. Slightly more than half of primary care physicians reported receiving financial incentives based on the quality or efficiency of care, although one-third of physicians continue to be paid exclusively on a fee-for-service basis. Three of 10 primary care physicians said their practice is qualified



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as a patient-centered medical home (PCMH) or advanced primary care practice. A similar share is currently participating in accountable care organizations (ACO). Nurse practitioners and physician assistants reported lower levels of participation in ACOs than did physicians, and many were unsure whether their practice participates in one or not.

Health information technology generally garnered positive opinions. Though seemingly counterintuitive, this finding is consistent with the literature: while providers tend to dislike transitioning from paper-based charts to electronic health record software, they generally accept the promise of HIT as a concept.[1] On other trends, primary care providers' views were divided or skewed negative. Both physicians and midlevel clinicians were more likely to say that increased use of medical homes is having a positive rather than a negative impact on the ability to provide quality care, but large shares said there has been no impact or they are not sure. Among providers working in practices that receive incentives for qualifying as medical homes, views were more positive.

In contrast, physicians' views tilt negative on the effect ACOs have had on the quality of care, and many are still not sure of their effect. Among physicians working in ACOs, views were divided between positive and negative. Providers were more negative about the use of quality metrics to assess their performance, even those providers who receive incentive payments based on quality. Nearly half of physicians and about a quarter of nurse practitioners and physician assistants said recent trends in health care are causing them to consider early retirement. However, a large majority of providers report satisfaction with their medical practice overall, consistent with historical data over the past two decades.[2,3]

## SURVEY FINDINGS IN DETAIL

### The Changing Primary Care Practice Environment

Current efforts to change primary care payment—that is, using new models that replace fee-for-service payment with other approaches—have been accelerated by provisions in the ACA. About two-thirds of primary care physicians (64%) reported they are paid either by capitation (i.e., prepayments for a set of services for a defined number of patients) or salary (i.e., predetermined income for an entire panel of patients) or through a combination of capitation, salary, and fee-for-service (Table 1). Nearly nine of 10 nurse practitioners and physician assistants (87%) reported receiving payment through mechanisms that are not exclusively fee-for-service. Nevertheless, about a third of primary care physicians (34%) are still paid exclusively on a fee-for-service basis. More than half (55%) of physicians and about a third (34%) of nurse practitioners and physician assistants said their practice receives incentives or payments based on measures of quality of care, patients' experiences, or efficiency of providing care. About one-third of nurse practitioners and physician assistants were unsure whether they had received such incentives.

Several newer models of delivering care, such as the patient-centered medical home (or PCMH, a model of care that emphasizes comprehensive care coordination, care teams, patient engagement, and population care management) and the accountable care organization (or ACO, a model in which several types of health care providers collectively take responsibility for the quality and costs of care for a population of patients), specifically aim to improve the way care is organized, paid for, and delivered. Twenty-nine percent of all primary care physicians said they participate in an ACO arrangement with Medicare or private insurers; 34 percent of those who accept Medicare also

**TABLE 1. PRACTICE CHARACTERISTICS**

| | Physicians | Nurse practitioners/ Physician assistants |
|---|---|---|
| Unweighted N | 1,624 | 525 |
| | % | % |
| Practice has consolidated with or been aquired by a group practice, a hospital, or another type of organization in the past two years | 17 | 16 |
| How are you paid for seeing patients? | | |
| Fee-for-service only | 34 | 10 |
| Capitation or salary, with/without fee-for-service | 64 | 87 |
| Provider or practice is currently receving incentives or payments based on the following: | | |
| Quality of care or patient experiences | 50 | 27 |
| Utilization or efficiency in care | 43 | 27 |
| Either quality/patient experiences or utilization/efficiency (NET) | 55 | 34 |
| Qualifying as a patient-centered medical home (PCMH) or advanced primary care practice (APCP) | 30 | 26 |
| Is your practice currently participating or preparing to participate in an ACO arrangement with Medicare or private insurers? | | |
| Yes, currently participating | 29 | 18 |
| Yes, preparing to participate | 9 | 6 |
| No | 32 | 19 |
| Not sure | 28 | 56 |
| Number of providers accepting Medicare | N=1,217 | N=377 |
| Among these, percent currently participating in ACOs | 34 | 22 |

Source: The Commonwealth Fund/Kaiser Family Foundation 2015 National Survey of Primary Care Providers.

said they participate (Table 1). Similarly, about 30 percent of physicians reported receiving incentives or payments for qualifying as a PCMH or through the ACA's Advanced Primary Care Practice (APCP) medical home demonstration.[4] Fewer than two of 10 (18%) nurse practitioners and physician assistants reported currently participating in an ACO, and about one-quarter (26%) said their practices qualified as a patient-centered medical home or an advanced primary care practice. A substantial percentage of providers (28% of physicians and 56% of nurse practitioners and physician assistants) are unsure whether their practices participate in ACO arrangements.

Another recent trend is the consolidation and acquisition of physician practices. The survey finds that about one of six providers (17% of physicians and 16% of nurse practitioners and physician assistants) reported their practices were acquired by or consolidated with a group practice, hospital, or another type of organization within the past two years (Table 1).

## Mixed Views of New Models and Tools

The survey asked primary care providers what effect, if any, they think these new models are having on providers' ability to provide high-quality care to patients. Health information technology received

the most positive ratings, with half (50%) of physicians and nearly two-thirds (64%) of nurse practitioners and physician assistants saying it has made a positive impact (Table 2).

Views were more mixed about medical homes and ACOs. Overall, one-third (33%) of physicians and four of 10 (40%) nurse practitioners and physician assistants said they believe medical homes are having a positive impact on quality of care (Exhibit 1), while roughly one of 10 said the impact has been negative. About a quarter of each group said there has been no impact or they are not sure. Among those in practices currently receiving incentives or payments for qualifying as a PCMH or APCP, larger percentages expressed positive views of the impact of medical homes (43% of physicians and 63% of nurse practitioners and physician assistants).

The potential of ACO arrangements to enhance quality of care also garnered mixed reviews, with large shares of providers unsure or negative about their impact. Physicians were more likely to view the increased prevalence of ACOs as having a negative (26%) rather than positive (14%) impact on quality of care, while nurse practitioners and physician assistants were more evenly split (Exhibit 2). Nearly four of 10 physicians (38%) and more than half of nurse practitioners and physician assistants (52%) were not sure of ACOs' effect on the quality of care provided to the nearly 24 million patients enrolled in them.[5] Among the 29 percent of physicians currently participating in an ACO, three of 10 said ACOs are having a positive impact, one-quarter said their impact is negative, and 20 percent said they have no impact. Even among physicians who participate in ACOs, one of four are still unsure of their impact.

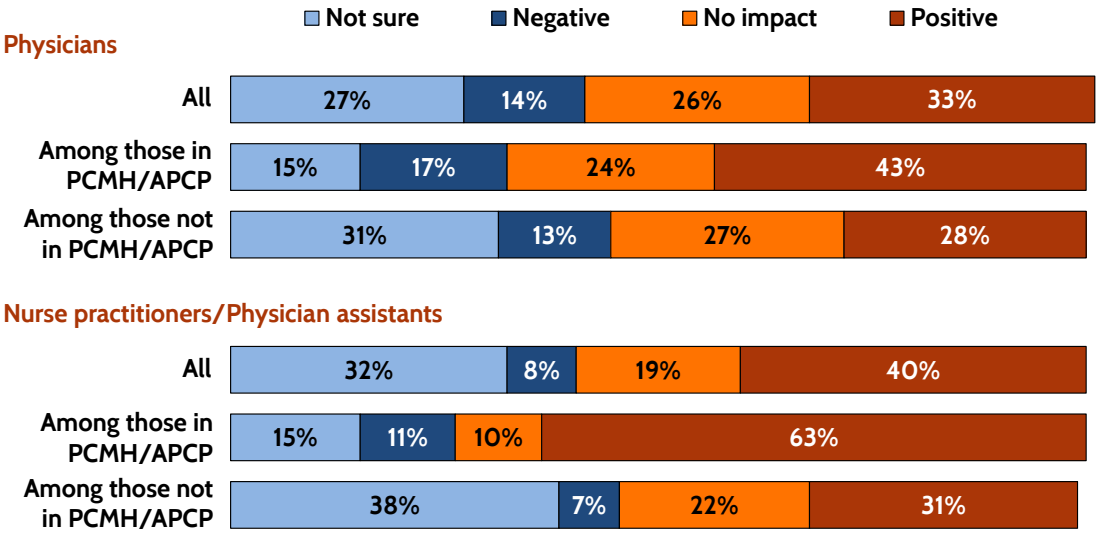
**TABLE 2. PROVIDERS' OPINIONS ABOUT THE IMPACT OF HEALTH INFORMATION TECHNOLOGY AND FINANCIAL PENALITIES FOR UNNECESSARY HOPSITAL ADMISSIONS ON QUALITY OF CARE FOR PATIENTS**

| | Physicians | Nurse practitioners/ Physician assistants |
|---|---|---|
| Unweighted N | 1,624 | 525 |
| | % | % |
| *Do you think each of the following is having a positive, negative, or no impact on primary care providers' ability to provide quality care to their patients?* | | |
| Increased use of health information technology | | |
| Positive impact | 50 | 64 |
| Negative impact | 28 | 20 |
| No impact | 10 | 8 |
| Not sure | 11 | 7 |
| Increased use of programs that include financial penalties for unnecessary hospital admissions or readmissions | | |
| Positive | 12 | 15 |
| Negative | 52 | 41 |
| No impact | 14 | 11 |
| Not sure | 21 | 32 |

Source: The Commonwealth Fund/Kaiser Family Foundation 2015 National Survey of Primary Care Providers.

## Exhibit 1. Providers' Views Are Mixed on Impact of Medical Homes, with Those Working in Medical Homes More Positive

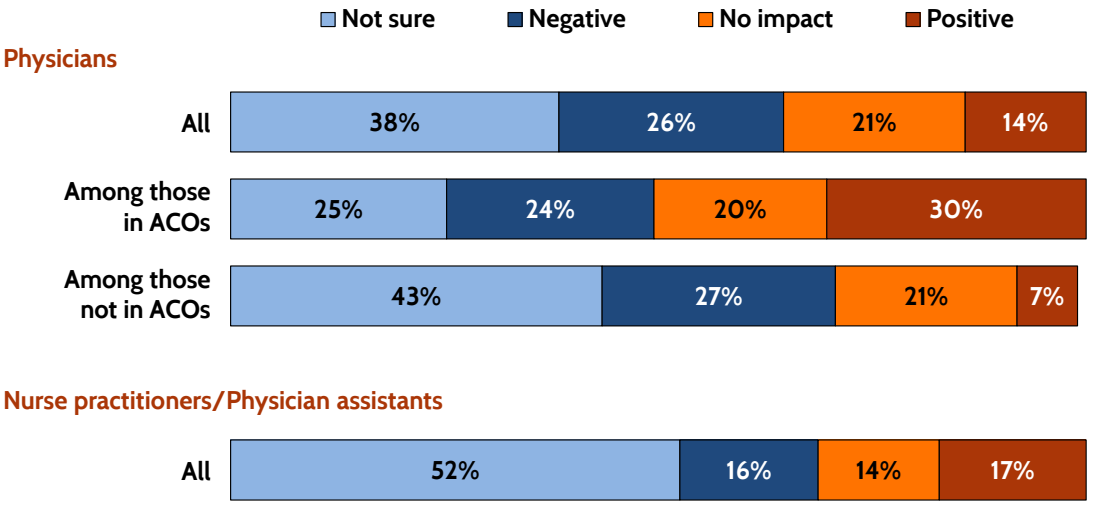
**Do you think the increased use of medical homes is having a positive, negative, or no impact on primary care providers' ability to provide quality care to their patients?**




Note: PCMH = patient-centered medical home; APCP = advanced primary care practice.
Source: The Commonwealth Fund/Kaiser Family Foundation 2015 National Survey of Primary Care Providers.

## Exhibit 2. Views on the Impact of Accountable Care Organizations Are Mixed, with Many Providers Unsure

**Do you think the increased use of accountable care organizations (ACOs) is having a positive, negative, or no impact on primary care providers' ability to provide quality care to their patients?**




Note: The number of NPs/PAs in ACOs is too small to analyze.
Source: The Commonwealth Fund/Kaiser Family Foundation 2015 National Survey of Primary Care Providers.

## Quality Metrics and Financial Penalties Are Unpopular with Providers

Perhaps unsurprisingly, the survey finds that performance assessments and financial penalties tied to patients' outcomes are unpopular among providers. Half of physicians (50%) and nearly four of 10 nurse practitioners and physician assistants (38%) feel that the increased use of quality metrics to assess provider performance is having a negative impact on quality of care. Far fewer providers (22% of physicians, 27% of nurse practitioners and physician assistants) perceived a positive effect (Exhibit 3). Positive views were only slightly higher among those providers who reported receiving quality-of-care-based incentives.

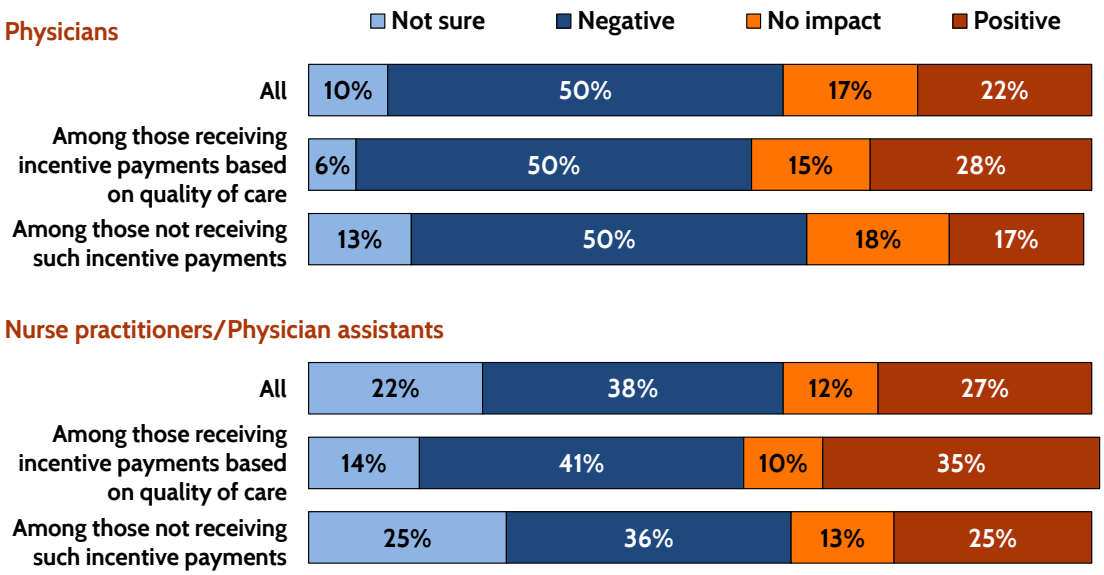
Similarly, fewer than one of six primary care providers (12% of physicians, 15% of nurse practitioners and physician assistants) said that programs that include financial penalties for unnecessary hospital admissions or readmissions have a positive effect on quality of care (Table 2). Far more providers—52 percent of physicians and 41 percent of nurse practitioners and physician assistants—think these financial penalties are having a negative effect.

## Views of Team-Based Care Differ Among Physicians vs. Nurse Practitioners and Physician Assistants

Many of the emerging models and tools to improve care delivery involve reorganization of staff roles, a shift to team-based care, and a greater reliance on nonphysicians.[6] Physicians have very different views from nurse practitioners and physician assistants about the use of nonphysician clinicians in primary care. Nearly nine of 10 (88%) nurse practitioners and physician assistants viewed this change positively, while only about one of three physicians (29%) agreed (Exhibit 4). Four of 10 physicians overall (41%) said this shift is negatively affecting providers' ability to provide quality care, but physicians' views largely depend on whether they have a nurse practitioner or physician assistant in

### Exhibit 3. Providers Are Largely Negative About Increased Use of Quality Metrics to Assess Provider Performance

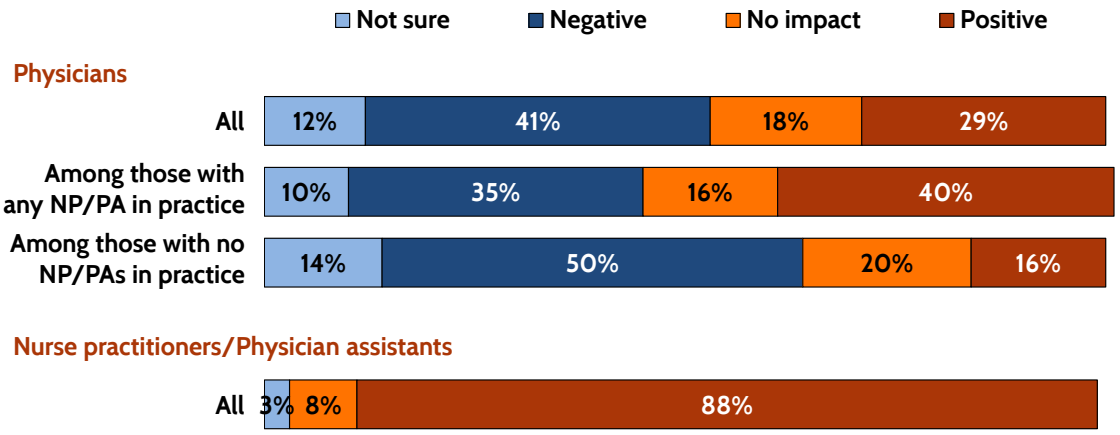
**Do you think the increased use of quality metrics to assess provider performance is having a positive, negative, or no impact on primary care providers' ability to provide quality care to their patients?**




Source: The Commonwealth Fund/Kaiser Family Foundation 2015 National Survey of Primary Care Providers.

## Exhibit 4. Physician Views Are More Negative Than Positive on Increased Reliance on Nurse Practitioners and Physician Assistants

**Do you think the increased reliance on nonphysician clinicians such as nurse practitioners (NPs) and physician assistants (PAs) is having a positive, negative, or no impact on primary care providers' ability to provide quality care to their patients?**




Source: The Commonwealth Fund/Kaiser Family Foundation 2015 National Survey of Primary Care Providers.

their practice. Among physicians with any nurse practitioner or physician assistant staff, 40 percent reported a positive view of this trend and 35 percent reported a negative view.

The survey also asked providers about teamwork and collaboration. When providers were asked whether they were satisfied with the level of collaboration with other team members in their practice, most said they were either somewhat or very satisfied (81% of physicians, 89% of nurse practitioners and physician assistants). However, more nurse practitioners and physician assistants than physicians said they were very satisfied (Exhibit 5). Physicians with any nurse practitioners or physician assistants in their practice (83%) and those without (79%) were generally satisfied with the level of collaboration in their practices.

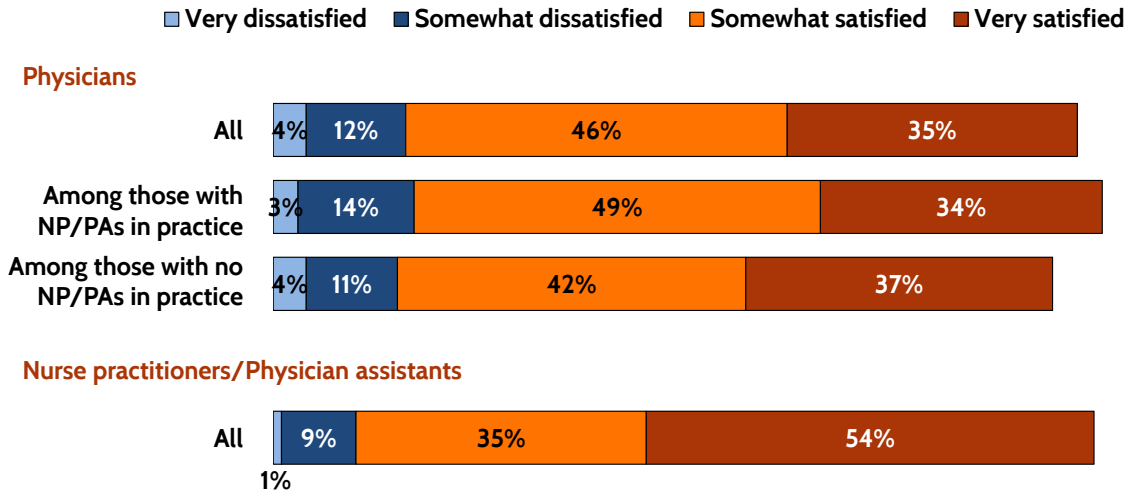
### Providers Rate Private Insurers More Positively Than Public Insurers

The survey asked providers to rate Medicaid, Medicare, and private insurers in terms of their reimbursement rates and administrative burden. On the whole, fewer than half of physicians gave positive ratings to any type of insurer on measures related to reimbursement, though ratings were higher for private insurers and lowest for Medicaid, with Medicare falling in the middle. Nearly half of physicians (46%) accepting private insurance considered these insurers' payment rates to be good or excellent, with far fewer physicians—only 11 percent—rating Medicaid as highly (Exhibit 6). Medicare ranked in the middle, with 21 percent of physicians who accept it for payment stating that payment rates are good or excellent.

Only 16 percent of physicians accepting Medicaid rated ease of reimbursement as good or excellent. Twice as many physicians accepting private insurance rated private insurers this highly (32%). Again, Medicare falls in the middle, with 25 percent of physicians rating ease of

## Exhibit 5. Nurse Practitioners and Physician Assistants Are More Satisfied Than Physicians with Collaboration

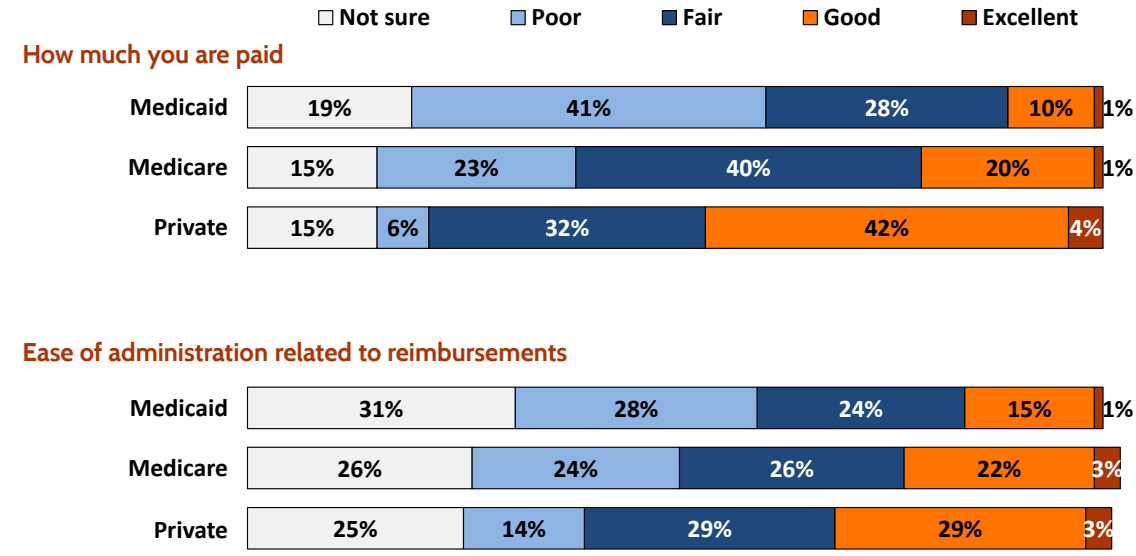
How satisfied are you with the level of collaboration with other team members in your medical practice?




Source: The Commonwealth Fund/Kaiser Family Foundation 2015 National Survey of Primary Care Providers.

## Exhibit 6. Physicians Are More Satisfied with Private Insurers Than Medicare and Medicaid on Payment and Administrative Burden

***Among physicians:*** In general, how would you rate public and private insurers when it comes to each of the following?



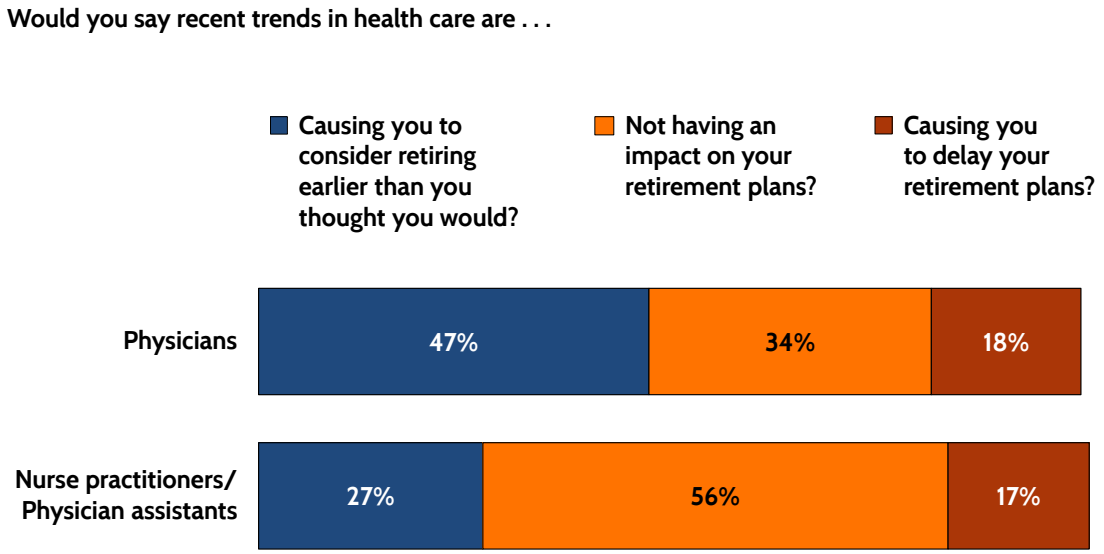

Note: For questions on Medicaid, base is among physicians who accept Medicaid; for questions on Medicare, base is among physicians who accept Medicare; for questions on private insurance, base is among physicians accepting private insurance.
Source: The Commonwealth Fund/Kaiser Family Foundation 2015 National Survey of Primary Care Providers.

reimbursement as good or excellent. Across the board, providers do not think Medicaid performs as well as either private insurance or Medicare in payment and administration. However, a substantial share of physicians said they were unable to assess any of these payers' performance. Nurse practitioners and physician assistants may be even more insulated from reimbursement issues and thus more apt to say they are unsure about insurers' payment practices (data not shown).

### Nearly Half of Physicians Say Trends Are Leading Them to Consider Early Retirement

Nearly half (47%) of physicians and about a quarter (27%) of nurse practitioners and physician assistants said that recent trends in health care are causing them to consider retiring earlier than they originally thought they would (Exhibit 7). While physician dissatisfaction is associated with early retirement, a look at historical trends shows that physician satisfaction levels have not changed dramatically over the past 20 years.[7] About one of six in each group said that trends are making them consider delaying their retirement (18% of physicians and 17% of nurse practitioners and physician assistants), while a third (34%) of physicians and more than half (56%) of nurse practitioners and physician assistants said these trends are not having much impact on their retirement plans.

## Exhibit 7. Nearly Half of Primary Care Physicians Say Health Care Trends Are Causing Them to Consider Early Retirement




Source: The Commonwealth Fund/Kaiser Family Foundation 2015 National Survey of Primary Care Providers.

## CONCLUSION

New primary care payment and delivery models have emerged in recent years as part of efforts to improve patient outcomes and lower health care costs, with the Affordable Care Act accelerating many of these changes. It may be too early to reach a conclusion on the quality or cost effects of these primary care reforms, but assessing the perspective and experience of those on the front lines is critical

to understanding the implementation of these reforms, including any challenges that could potentially undermine the process.

The survey results indicate that primary care providers' views of many of these new models are more negative than positive. There are exceptions: health information technology gets mostly positive views and medical homes receive mixed opinions with a positive tilt. With regard to HIT, our study indicates that primary care providers generally accept the promise of HIT to improve quality of care even if previous research shows they dislike the process of transitioning from paper-based records.[8] Our survey results also may reflect clinicians' earlier exposure to certain models and tools. National adoption of electronic health records received a boost from the Health Information Technology for Economic and Clinical Health (HITECH) Act of the federal stimulus package of 2009, while the four primary care specialty societies announced a joint statement regarding medical homes in February 2007, several years before passage of the Affordable Care Act.

Though many providers are unsure of the impact of ACOs on quality of care, those physicians who do have an opinion are more likely to say ACOs are a having a negative rather than a positive impact on quality of care. ACO implementation is a somewhat more recent development, and primary care providers are not as involved in the day-to-day management of organizational change. Primary care clinicians' views are also decidedly negative when it comes to financial penalties and the increased use of quality metrics in judging their performance. It may be some time before they can become comfortable with these new payment models.

More primary care providers may be participating in ACOs and relying on quality metrics for performance assessment in the near future. In early 2015, the Centers for Medicare and Medicaid Services announced that 85 percent of Medicare fee-for-service payments should be tied to quality or value by 2016. And, by the end of 2018, 50 percent of all Medicare payments should be tied to quality or value through specific alternative payment models, like ACOs and bundled payments.[9] Dissatisfaction with new models may not be solely attributable to a difficult transformation process; larger culture change within the practice of medicine may be a necessary first step before delivery system reforms such as ACOs and medical homes are fully accepted on the ground.

As primary care transformation efforts mature and spread, it will remain important to judge their effects on patients in terms of access, quality, and costs of care. However, it is also important to assess their effect on primary care clinicians. Of concern, nearly half of primary care physicians say that recent trends in health care are causing them to consider retiring earlier than planned. Market trends in health care have been affecting physicians' satisfaction for more than 20 years. It will be important to monitor providers' satisfaction with delivery reform efforts.

## Notes

[1] M. W. Friedberg, P. G. Chen, K. R. Van Busum et al., *Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy* (Santa Monica, Calif.: RAND Corporation, 2013).

[2] The Kaiser Family Foundation and The Commonwealth Fund, *Experiences and Attitudes of Primary Care Providers Under the First Year of ACA Coverage Expansion—Findings from the Kaiser Family Foundation/Commonwealth Fund 2015 National Survey of Primary Care Providers* (Menlo Park, Calif., and New York: The Henry J. Kaiser Family Foundation and The Commonwealth Fund, June 2015).

[3] B. E. Landon, J. Reschovsky, and D. Blumenthal, "Changes in Career Satisfaction Among Primary Care and Specialist Physicians, 1997–2001," *Journal of the American Medical Association,* Jan. 22–29, 2003 289(4):442–49.

[4] FQHC Advanced Primary Care Practice Demonstration, http://innovation.cms.gov/initiatives/fqhcs/.

[5] D. Muhlestein, "Growth and Dispersion of Accountable Care Organizations in 2015," *Health Affairs Blog,* March 31, 2015, http://healthaffairs.org/blog/2015/03/31/growth-and-dispersion-of-accountable-care-organizations-in-2015-2/.

[6] E. H. Wagner, K. Coleman, R. J. Reid et al., "The Changes Involved in Patient-Centered Medical Home Transformation," *Primary Care: Clinics in Office Practice,* June 2012 39(2):241–59.

[7] B. E. Landon, J. D. Reschovsky, H. H. Pham et al., "The Consequences of Physician Dissatisfaction," *Medical Care,* March 2006 44(3):234–42; Landon, Reschovsky, and Blumenthal, "Changes in Career Satisfaction," 2003.

[8] Friedberg, Chen, Van Busum et al., *Factors Affecting Physician Professional Satisfaction,* 2013.

[9] S. M. Burwell, "Setting Value-Based Payment Goals—HHS Efforts to Improve U.S. Health Care," *New England Journal of Medicine,* March 5, 2015 372(10):897–99.

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## Methodology

The Commonwealth Fund/Kaiser Family Foundation 2015 National Survey of Primary Care Providers was jointly designed and analyzed by researchers at The Kaiser Family Foundation (KFF) and The Commonwealth Fund. Social Science Research Solutions (SSRS) carried out the field work and collaborated with Kaiser and Commonwealth Fund researchers on questionnaire design, pretesting, sample design, and weighting. The Kaiser Family Foundation and The Commonwealth Fund each contributed financing for the survey. The project team included Jamie Ryan, Michelle Doty, Rose Kleiman, and Melinda Abrams from The Commonwealth Fund; and Liz Hamel, Mira Norton, and Mollyann Brodie from Kaiser.

Survey responses were collected via hard copy and Web-based questionnaires between January 5 and March 30, 2015, with a random sample of 1,624 primary care physicians and a separate random sample of 366 nurse practitioners (NPs) and 159 physician assistants (PAs) working in primary care practices. The surveys achieved the following response rates, calculated using AAPOR's RR3: physicians (34%), NPs (29%), and PAs (25%).

The sample for physicians was procured from SK&A, which maintains a national database of physicians that is continuously updated by a telephone verification process. Physicians drawn for the sample were those whose specialty was listed in the SK&A database as either general practice, family practice, internal medicine, adolescent medicine, internal medicine pediatrics, general pediatrics, or geriatrics. Physicians were further screened to include only those who indicated in the survey that they spend at least 60 percent of their work time providing care to patients as a primary care provider. The physician sample included an oversample of physicians working in low-income areas (those whose office is located in a zip code where the average annual household income is $55,000 or less) and those working in federally qualified health centers and community health centers.

The sample for NPs/PAs was procured from KM Lists, which uses publicly released data available from state licensing boards and information from professional associations and journal subscriptions to develop and update its database. Unlike physicians, specialty type for NPs and PAs does not necessarily correspond with the practice setting in which they work. Therefore, a broader list of specialties was included. NPs and PAs drawn for the sample were those whose specialty was listed in the database as family medicine, internal medicine, adult medicine, adolescent medicine, pediatrics, internal medicine pediatrics, geriatrics, preventive medicine, osteopathy, women's health, or community/public health. The sample also included NPs and PAs whose specialty type was listed as "unknown" (these were undersampled relative to the other listed specialties). NPs and PAs were further screened to include only those who indicated in the survey that they are currently working in a primary care practice and that they spend at least 60 percent of their work time providing care to patients as a primary care provider.

In an effort to maximize contact and completion rates, providers were contacted by multiple modes (mail, telephone, and email), offered incentives, and given the option of completing the survey in hard copy or online.

A multistage weighting process was applied to ensure an accurate representation of the national population of primary care physicians and NPs/PAs. The first stage in weighting both samples involved corrections for sample design and differential nonresponse by email availability. Physician survey data were weighted by gender, age, specialty type, region, and site specialty using benchmarks in the 2014 American Medical Association Physicians Masterfile; and number of MDs at site using benchmarks in the SK&A list of primary care MDs. NP and PA data were weighted by gender and specialty type using benchmarks in the KM Lists. The physician sample was analyzed separately from the NP and PA sample.

All statistical tests of significance account for the effect of weighting. The margin of sampling error (MOSE) including the design effect is plus or minus 3 percentage points for MDs and 5 percentage points for the combined group of NPs and PAs. Unweighted Ns and MOSE for NPs and PAs separately are shown in the table below. For results based on other subgroups, the MOSE may be higher.

| Group | N (unweighted) | MOSE |
|---|---|---|
| MDs | 1,624 | ±3 percentage points |
| NPs/PAs combined | 525 | ±5 percentage points |
| NPs only | 366 | ±6 percentage points |
| PAs only | 159 | ±9 percentage points |

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